	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
					С
		345405	B. WING		10/01/2021
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CHARLOT	TE HEALTH & REHABI	LITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	. ,
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 000	INITIAL COMMENTS	5	F 00	o	
	from 09/29/21 throug	ation survey was conducted gh 10/01/21. 5 of the 31 s were substantiated resulting it ID# 2OM811.			
F 684 SS=D	Quality of Care CFR(s): 483.25		F 68	4	10/25/21
	applies to all treatment facility residents. Base assessment of a resist that residents receive accordance with pro- practice, the compre- care plan, and the resist This REQUIREMENT by: Based on observation review, the facility far daily per physician on Resident #11 did not non-pressure chronic and non-pressure chronic 2 days. Resident #12 to an unstageable de left heel for 1 day. The residents sampled for and Resident #12). The findings included 1. Resident #11 was 1/10/20. Diagnoses in	T is not met as evidenced ons, interviews and record iled to provide wound care order to 2 sampled residents. It receive wound care to a c left heel ulcer and a c ulcer of the right midfoot for 2 did not receive wound care eep tissue injury (DTI) to the his occurred for 2 of 2 or wound care (Resident #11		The statements made in the following plan of correction are not an admissio and do not constitute an agreement w the alleged deficiencies nor the report conversations and other information of in support of the alleged deficiencies. facility sets forth the following plan of correction to remain in compliance wit federal and state regulations. The fac has taken or will take the actions set f in the plan of correction. The followin plan of correction constitutes the facili allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicate F684	n to rith ted The th all cility forth g g ity⊡s
	non-pressure chronie			F684 1. Address how corrective action wi	ll be

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/25/202 RM APPROVEI NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		ATE SURVEY MPLETED
		345405	B. WING				0/01/2021
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			35 TODDVILLE ROAD HARLOTTE, NC 28214		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Continued From page	e 1	F 6	84			
	osteomyelitis left ank	le and foot, among others.			accomplished for those residents for have been affected by the deficient	ound to	
	Resident #11 had act potential for further b	n 8/31/21 documented ual skin breakdown, reakdown regarding the d DM and was followed by a			practice "Resident #11 and #12: wound was completed by the nurse and wo physician on 9/29/21. Wound condi	ound	
	treat the wounds as o	olan interventions included to ordered. Data Set assessment and a			were observed and assessed by the wound physician 9/29/21 during wo rounds. Wound MD was notified of	und	
	Care Area Assessme assessed Resident #	nt (CAA), both dated 9/1/21,			missed treatments and assessed w no new orders given. "Resident #11 was provided with heel protectors		
	for changes in skin in	tegrity due to current diagnoses of PVD, current			" One on one education provided responsible charge nurse by both the manager and DON on providing wo	ne unit	
	CAA documented Re completed antibiotic t	herapy for osteomyelitis of			<ul><li>care per MD orders and shift chang reporting.</li><li>Address how the facility will ide</li></ul>	entify	
	doctor (WD) for woun	l was followed by a wound ids to his bilateral feet.			other residents having potential to b affected by the same deficit practice " On 9/29/21, Nurse and wound	e	
		and Management Summary eed Resident #11 with e following:			physician conducted an audit of res receiving wound care. No other issu were identified. Completed on 9/29/ " 9/30/21, DON interviewed 1000	ues /21	
	duration of greater the	e right lateral foot for a an 126 days. The wound er (cm) by 0.8 cm by 1 cm,			<ul><li>residents receiving wound care.</li><li>3. Address what Measures will be into place or systemic changes made</li></ul>	•	
	granulation tissue and	date (bloody drainage), 80% d 20% muscle and fascia. was noted as improved.			ensure that the deficient practice wi reoccur Licensed nurses will be in-serv facility s policy for wound documer	iced on	
	than 130 days. The w cm by 0.3 cm, moder	oot for a duration of greater vound measured 17 cm by 5 ate serous exudate, 20%			<ul><li>All residents receiving wound of at risk for this deficient practice.</li><li>Any Licensed Nurse who is not</li></ul>	are are	
	, <u> </u>	30% granulation tissue, and bone and 20% skin. The noted as improved.			educated will not be allowed to worl education received. " Any new Licensed Nurses will		

Facility ID: 943091

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		345405	B. WING		С	
		343405		STREET ADDRESS, CITY, STATE, ZIP CODE	10/01/2021	
NAME OF P	ROVIDER OR SUPPLIER					
CHARLO	TTE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	
F 684	Continued From page	2	F 684	L		
	A physician (MD) orde apply calcium alginate right lateral foot daily discontinued on 9/27/ A MD order dated 9/2 Betadine and border g daily on day shift. A MD order dated 9/2 the left foot/heel with Betadine and Hydrog (nonsterile highly abs wounds), and wrap w On 9/29/21, Resident AM in bed on an air m protector was observe heel protector was vis discharge. A dressing right lateral foot. The visible. An observation occurr with Resident #11 in H A foam heel protector and it was visibly soile exterior with a red-ting removed the foam he dressing dated 9/26/2 of Nurse #1. The wou was also dated 9/26/2 of Nurse #1. There was	er dated 8/12/21 recorded to e and border gauze to the on day shift. This order was 21. 7/21 recorded to apply gauze to the right lateral foot 7/21 recorded to cleanse wound cleanser, apply el, cover with ABD pad orbent pad used for large ith Kerlix daily on day shift. #11 was observed at 11:35 nattress. A foam heel ed to his left foot. The foam sibly soiled with a red-tinged g was observed intact to the date of the dressing was not red on 9/29/21 at 2:42 PM his room on an air mattress. was intact to his left foot ed to both the interior and ged drainage. Nurse #1 el protector and removed a 21 which recorded the initials ind bed and the dressing		<ul> <li>educated by Staff Development Nu Director of Nursing or designee dur orientation process, prior to providi wound care.</li> <li>Indicate how the facility plans to monitor its performance to make su solutions are sustain <ul> <li>Unit manager or designee will complete wound audits to ensure the dressing changes are complete as prescribed by physician. This audit take place 5x/wk x 4wks, then 3x/w 4wks, and then weekly during roun wound physician x 4wks.</li> <li>Unit manager will review any w concerns during the daily clinical me in the results of this audit data with reported by the Director of Nursing Administrator to the Quality Assura Committee for review and recommendations given in order to in ensuring that the facility stays in compliance and if concerns are ide the Quality Assurance Committee wo on additional weeks until compliance sustained. Once the QA committee determines the problem no longer of then the audits will be conducted of random basis.</li> <li>The Director of Nursing and Admini- are responsible for implementing at maintaining the acceptable plan of correction.</li> </ul> </li> </ul>	ring ng to ure that hat will k x ds with vound eeting rill be and or nce assist ntified vill add ce is exist, n a istrator nd	

Facility ID: 943091

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE	
		345405	B. WING				C / <b>01/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
					1735 TODDVILLE ROAD		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	wounds on 9/26/21. S explain why the dress Resident #11 stated to care to his feet "a cou The WD reviewed the Resident #11 on 9/29 confirmed that the wo daily dressing change wound and stated the and that she ordered control drainage and the drainage to the left for dressing changed per wound care was not p 9/28/21, the wounds of A telephone interview PM with Nurse #2. Sh AM - 3 PM nurse for F 9/28/21. Nurse #2 state wound care to Reside because she looked a wound orders to his fe Nurse #2 further state wound care to the Re because when she wo the wound care, he has and she planned to re to his feet but did not that she did not report A telephone interview Manager (UM) on 10/ stated that the charge	essings she applied to both She stated she could not sings had not been changed. hat he last received wound uple days ago." e medical record for /21 at 2:55 PM and bund care orders were for es. The WD assessed each e wounds were improving daily dressing changes to to meet the goals of wound ed that she wanted the ot well controlled with the r order, but even though provided on 9/27/21 and did not deteriorate. r occurred on 9/30/21 at 2:20 he stated that she was the 7 Resident #11 on 9/27/21 and ted she did not provide ent #11's feet on 9/27/21 at the orders and thought the eet had been discontinued.	F	68			
		and if the care could not be nurse should report off to the					

Facility ID: 943091

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY
		345405	B. WING	ING .			С
	ROVIDER OR SUPPLIER	343403	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	10	/01/2021
	NOVIDER OR OOI T EIER				1735 TODDVILLE ROAD		
CHARLO	TE HEALTH & REHABIL	ITATION CENTER			CHARLOTTE, NC 28214		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	routinely ran a report wound care had or ha she could follow up if done. The Director of Nursir on 9/30/21 at 2:30 PM MD order should be for should be provided da ordered. The DON als was interrupted while unable to provide the report off to the oncor would run a report tha wound care that still r 2. Resident #12 was a 8/23/21. Diagnoses ir heel DTI, and type 2 of others. An admission weekly 8/25/21 documented unstageable left heel centimeters (cm) by 4 An admission Minimu and Care Area assess assessed Resident # clear speech, underst cognition and admitted with 100% necrotic (d A care plan dated Aug #12 was at risk for fur a DTI on admission to	se. The UM stated that she that allowed her to see what ad not been provided so that any wound care did not get ng (DON) was interviewed A. The interview revealed the ollowed and wound care aily if that's what the doctor so stated that if the nurse providing wound care and care, the nurse should ming nurse, and the UM at would let her see any needed to be provided. admitted to the facility ncluded an unstageable left diabetes mellitus, among skin evaluation dated Resident #12 with an DTI, that measured 5 4.7 cm by 0.1 cm. Im Data Set assessment sment, both dated 8/26/21, 12 with adequate hearing, tood/understands, intact ad with one unstageable DTI lead) tissue to the left heel. gust 2021 identified Resident ther skin impairment due to b her left heel. Interventions clean and dry and provide	F	684			

Facility ID: 943091

If continuation sheet Page 5 of 14

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED IO. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED		
		345405	B. WING			1	C 0/01/2021		
NAME OF P	ROVIDER OR SUPPLIER	L	<b>I</b>	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<b>.</b>			
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214					
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 684	Continued From page	9 5	F	684					
		ed 9/1/21 recorded to with wound cleanser, apply and cover with dry dressing							
	AM in bed on an air n observed off-loaded w intact, but the date wa stated that she typica her left heel, but that care on yesterday (9/ that the nurse came i all the supplies to pro that the nurse got cal	served on 9/29/21 at 11:42 nattress. Her feet were with pillows. A dressing was as not visible. Resident #12 Ily received wound care to she did not receive wound 28/21). Resident #12 stated nto her room on 9/28/21 with vide the wound care, but led away and did not come nd care was not provided.							
	was positioned on a p off-loaded. A dressing The dressing was dat initials of Nurse #1. N dressing to the left he wound care to Reside also stated that the cu Resident's left heel w placed on 9/27/21. No she did not provide w on 9/28/21 because s	n air mattress. Her left leg pillow and her left heel was g was intact to her left heel. ted 9/27/21 and recorded the lurse #1 removed the sel and stated she provided ent #12 on 9/27/21. Nurse #1 urrent dressing intact to the as the dressing Nurse #1 urse #1 further stated that ound care to Resident #12 she was off and that she of the dressing she applied on							
	wound for Resident # and stated that Resid left heel DTI with 100	VD) assessed the left heel 12 on 9/29/21 at 1:45 PM ent #12 had an unstageable % necrotic tissue on ity. She stated that the							

Facility ID: 943091

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/25/2021 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345405	B. WING			_		C 01/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		•
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			735 TODDVILLE ROAD HARLOTTE, NC 28214	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	the wound bed had an tissue and the rest of tissue. The WD further daily dressing change expected the dressing daily. A telephone interview PM with Nurse #2. Nut the 7 AM - 3 PM Nurse 9/28/21. Nurse #2 fur gathered the wound so the shift and went into 9/28/21 to provide wo pulled away to another not come back to prov #2 stated that she rep nurse that the wound A telephone interview at 4:13 PM with Nurse to work on 9/28/21 at she received report fr stated that the report an update that wound for Resident #12. Nur not aware of this, she care to Resident #12. A telephone interview Manager (UM) on 10/ stated that the charger wound care per order provided the charge nur- routinely ran a report	00% necrotic tissue, but now pproximately 50% necrotic the wound bed had healthy er stated that she ordered es to the left heel DTI and g changes to be completed r occurred on 9/30/21 at 2:12 urse #2 stated that she was se for Resident #12 on ther stated that she supplies towards the end of o Resident #12's room on ound care, but that she got er resident's room and did vide the wound care. Nurse ported to the oncoming care had not been provided. r was conducted on 9/30/21 e #3 who stated she arrived 5:30 PM, when she arrived, om Nurse #2. Nurse #3 she received did not include I care had not been provided se #3 stated since she was also did not provide wound	F	684				
	A telephone interview Manager (UM) on 10/ stated that the charge wound care per order provided the charge r oncoming charge nur routinely ran a report wound care had or ha	occurred with the Unit 1/21 at 11:04 AM. The UM e nurse should provide and if the care could not be nurse should report off to the se. The UM stated that she that allowed her to see what						

		D HUMAN SERVICES				FORM	M APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ripi f	CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							с
		345405	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	01/2021
NAME OF PI	ROVIDER OR SUPPLIER				735 TODDVILLE ROAD		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			CHARLOTTE, NC 28214		
(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 684	Continued From page done. The Director of Nursir on 9/30/21 at 2:30 PM MD order should be for should be provided da ordered. The DON als was interrupted while unable to provide the report off to the oncor would run a report that wound care that still m Resident Records - Id CFR(s): 483.20(f)(5), §483.20(f)(5) Residen (i) A facility may not re resident-identifiable to accordance with a con agrees not to use or of except to the extent the to do so. §483.70(i) Medical ref §483.70(i)(1) In accor professional standard must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org	e 7 ng (DON) was interviewed A. The interview revealed the blowed and wound care aily if that's what the doctor so stated that if the nurse providing wound care and care, the nurse should ning nurse, and the UM at would let her see any needed to be provided. lentifiable Information 483.70(i)(1)-(5) at-identifiable information. elease information that is to the public. lease information that is to an agent only in ntract under which the agent disclose the information he facility itself is permitted cords. dance with accepted s and practices, the facility al records on each resident ented; a; and ganized	F	842	DEFICIENCY)		10/25/21
	all information contain	lity must keep confidential ned in the resident's records, n or storage method of the					

Facility ID: 943091

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345405	B. WING				01/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			1735 TODDVILLE ROAD CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 842	records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to heal by and in compliance §483.70(i)(3) The facil record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yeal legal age under State §483.70(i)(5) The mean (i) Sufficient information (ii) A record of the ress (iii) The comprehensiv provided;	release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance stactivities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed	F	842			

Facility ID: 943091

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/25/2021 M APPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345405	B. WING		10/01/2021			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			735 TODDVILLE ROAD HARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page (vi) Laboratory, radio	e 9 logy and other diagnostic	F	842				
		equired under §483.50. is not met as evidenced						
	review, the facility fail the Treatment Admin	ns, interviews and record led to accurately document istration Record (TAR) for			F842			
		to 2 sampled residents care (Resident #11 and			How corrective action will be accomplished for each resident found have been affected by the deficient	to		
	The findings included				practice: " Resident #11 and Resident #12 di not have any documentation of wound			
	1/10/20. Diagnoses in disease (PVD), type 2	admitted to the facility ncluded peripheral vascular 2 diabetes mellitus (DM),			care being performed Wound MD wa notified on 09/29/21 of the missed treatments and assessed wounds with			
		ulcer of left heel, ulcer of midfoot, and le and foot, among others.			new orders. " Responsible charge nurse was educated on proper wound documenta			
	An annual Minimum I assessed Resident #	Data Set dated 9/1/21, 11 with clear speech			<ul> <li>TAR was correct to reflect that wo care was not given</li> <li>Wound MD completed updated</li> </ul>	und		
	understood/understa	nds, and intact cognition.			documentation on 9/29/21 How corrective action will be			
		er dated 9/27/21 recorded to order gauze to the right ay shift.			accomplished for those residents having the potential to be affected by the sam deficient practice: " Residents who receive wound car	e		
	the left foot/heel with	27/21 recorded to cleanse wound cleanser, apply el, cover with ABD pad			was audited for completion of documentation and accuracy of documentation.			
	(nonsterile highly abs	orbent pad used for large ith Kerlix daily on day shift.			Measures to be put in place or system changes made to ensure practice will r re-occur:			
		t #11 recorded the initials of nd care to both feet on			" Licensed nurses will be educated facility process for wound documentati by SDC or designee			
	An observation occur	red on 9/29/21 at 2:42 PM			" DON or designee will audit ETAR completion of wound care 5x weekly x	4		

Facility ID: 943091

CENTER		ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	OME	ORM APPROVE <u>3 NO. 0938-039</u> DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	IG		C
		345405	B. WING			10/01/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE	
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 842	A foam heel protector Nurse #1 removed the removed a dressing of recorded the initials of observation, the would dressing to the right I dated 9/26/21. Nurse wound care to Reside the dressings that we dressings she applied She stated she could dressings had not be stated that he last red "a couple days ago." A telephone interview PM with Nurse #2. SI AM - 3 PM nurse for Nurse #2 stated she to the Resident's feet she went into his root he had an incontinen return to provide would not return. Nurse #2 documented on the T wound care was prov- entering the Residen wound care. Nurse # have recorded the would care. She stated that medical record prior to bad habit she needed	his room on an air mattress. r was intact to his left foot. le foam heel protector and dated 9/26/21 which of Nurse #1. During the same nd doctor (WD) removed a ateral foot that was also #1 stated she provided ent #11 on 9/26/21 and that ere just removed were d to both wounds on 9/26/21. I not explain why the en changed. Resident #11 ceived wound care to his feet w occurred on 9/30/21 at 2:20 he stated that she was the 7 Resident #11 on 9/28/21. did not provide wound care t on 9/28/21 because when m to provide the wound care, t episode and she planned to und care to his feet but did also stated that she CAR for Resident #11 that wided on 9/28/21 prior to t's room to provide the 2 stated that she should not bund care was provided e and since she did that, the Id not know to provide the recording care in the to providing the care was a	F 8	weeks, then weekly x 4 monthly x 1 " Any Licensed Nurse educated will not be all education received on documentation. " Any new Licensed educated by Staff Deve Director of Nursing or co orientation process How facility will monito action(s) to ensure defining not re-occur:	se who is not lowed to work until proper wound I Nurses will be elopment Nurse or designee during r corrective icient practice will lits will be reviewed surance Meeting X if needed. Once ermines the at, then the audits random basis. g and Administrator olementing and able plan of	
	Manager (UM) on 10	/1/21 at 11:04 AM. The UM e nurse should provide				

Facility ID: 943091

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345405	B. WING				C 01/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHARLO	TE HEALTH & REHABIL	ITATION CENTER			1735 TODDVILLE ROAD CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 842	<ul> <li>wound care per order provided the charge r oncoming charge nur- should not be docume provided. The UM stat that allowed her to se so that she could follo not get done and if ca provided, but had not report would be inacco The Director of Nursir on 9/30/21 at 2:30 PM nurse was interrupted and unable to provide report off to the oncor further stated the med accurately record the provided.</li> <li>Resident #12 was a 8/23/21. Diagnoses in heel deep tissue injur mellitus, among other</li> <li>An admission Minimu dated 8/26/21, assess adequate hearing, cle understood/understar</li> <li>A physician (MD) orde cleanse the left heel w Santyl (debridement) daily on day shift.</li> <li>The TAR for Resident</li> </ul>	and if the care could not be burse should report off to the se. The UM stated that care ented until after it is ted that she ran a report e the status of wound care ow up if any wound care did are was documented as actually been done, her urate. Ing (DON) was interviewed M. The DON stated that if the while providing wound care the care, the nurse should ming nurse. The DON dical record should care that has been admitted to the facility included an unstageable left y (DTI), and type 2 diabetes rs. m Data Set assessment sed Resident #12 with	F	842			

If continuation sheet Page 12 of 14

DEPART CENTER	FORM APPROVED OMB NO. 0938-0391							
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/01/2021		
		345405	B. WING					
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CHARLOTTE HEALTH & REHABILITATION CENTER					1735 TODDVILLE ROAD CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 842	TE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Resident #12 was observed on 9/29/21 at 11:42 AM in bed on an air mattress. A dressing was intact to her left heel, but the date was not visible. Resident #12 stated that she typically received wound care to her left heel, but that she did not receive wound care on yesterday (9/28/21). Resident #12 stated that the nurse came into her room on 9/28/21 with all the supplies to provide the wound care, but that the nurse got called away and did not come back and so the wound care was not provided. On 9/29/21 at 1:45 PM, Resident #12 was observed in bed on an air mattress. A dressing was intact to her left heel. The dressing was dated 9/27/21 and recorded the initials of Nurse #1. Nurse #1 removed the dressing to the left heel and stated she provided wound care to Resident #12 on 9/27/21. Nurse #1 also stated that the current dressing intact to the Resident's left heel was the dressing Nurse #1 placed on 9/27/21. Nurse #1 further stated that she did not provide wound care to Resident #12 on 9/28/21 because she was off and that she could not explain why the dressing she applied on 9/27/21 was still in place. A telephone interview occurred on 9/30/21 at 2:12 PM with Nurse #2. Nurse #2 stated that she gathered the wound supplies towards the end of the shift and went into Resident #12 on 9/28/21. Nurse #1 further stated that she gathered the wound care, but that she got pulled away to another resident's room and did not come back to provide the wound care. She stated that she recorded in the medical record that the wound care had been provided prior to giving the care. Nurse #2 further stated that		F	842				

Facility ID: 943091

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 10/25/2021 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345405	B. WING		_	C 10/01/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	10/0		
CHARLO	TE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD CHARLOTTE, NC 28214	4			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 84	2				

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