PRINTED: 01/21/2025 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345405	B. WING _			C 12/23/2024
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	ZIP CODE	12/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED		5.475
F 000	INITIAL COMMENT	'S	FC	000		
	on 12/16/24 through action plans were vertherefore the exit da The following intake NC00225078, NC00 of the 8 complaint a	gation survey was conducted in 12/17/24. The corrective alidated on 12/23/24, ate was changed to 12/23/24. The swere investigated: 0224178 and NC00225004. 4 Illegations resulted in a C00225078 resulted in .				
	Past-noncompliance	e was identified at:				
	of J. CFR 483.12 at tag I of J. CFR 483.25 at tag I of J. CFR 483.35 at tag I of J.	F580 at a scope and severity F600 at a scope and severity F684 at a scope and severity F726 at a scope and severity F760 at a scope and severity				
	Substandard Qualit	4 and F760 constituted y of Care. began on 11/30/24 and was A partial extended survey was				
F 550 SS=D	§483.10(a) Residen	1)(2)(b)(1)(2) t Rights.	F 5	550		1/23/25
	self-determination, access to persons a outside the facility, i	right to a dignified existence, and communication with and and services inside and ncluding those specified in				
I ADODATODY	DIDECTOR'S OF BROVINE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	_	TITI F		(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the data of automatical provided. For purpose, the phone findings and place of correction and disclosable 14.

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	ı	12/23/2024	
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F 550	with respect and dig resident in a manne promotes maintenar her quality of life, reindividuality. The factor promote the rights of \$483.10(a)(2) The faccess to quality call severity of condition must establish and reprovision of services residents regardless. \$483.10(b) Exercises The resident has the rights as a resident or resident of the Ur \$483.10(b)(1) The face sident can exercise interference, coercise from the facility.	lity must treat each resident nity and care for each r and in an environment that ace or enhancement of his or cognizing each resident's cility must protect and f the resident. Acility must provide equal re regardless of diagnosis, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all to of payment source. Of Rights. The right to exercise his or her of the facility and as a citizen	F 5	550			
	subpart. This REQUIREMEN by: Based on record re interviews, the facilit	r rights as required under this T is not met as evidenced view and resident and staff y failed to treat a resident in a ile providing incontinent care		The facility sets forth the follow correction to remain in complia federal and state regulations.	nce with all		

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NAME OF D	ROVIDER OR SUPPLIER	0.70.700	1	STREET ADDRESS, CITY, STATE, ZIP	12/23/2024
NAME OF T	NOVIDEN ON 3011 LIEN			1735 TODDVILLE ROAD	CODE
CHARLOT	TE HEALTH & REHA	ABILITATION CENTER			
				CHARLOTTE, NC 28214	
(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 CEACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 550	Continued From p	page 2	F 5	550	
F 550	and failed to effect 1 of 3 residents re #3). Resident #3 s "disrespected and and made to stay The findings inclu- Resident #3 was a 4/11/2016 with dia hand, overactive to pulmonary diseas The care plan dat The problem state bladder and bowe toileting program and bladder due to The goal stated th clean and dry as p included the resid for bed mobility, 1 check and change The quarterly Min assessment date Resident #3 was a extensive assistar always incontinen refusal of care wa reference period.	tively respond to a call light for eviewed for dignity (Resident stated that she felt a upset that she was ignored in a soiled brief." ded: admitted to the facility on agnoses of contracture of left bladder, and chronic obstructive e. ded 11/12/2024 was reviewed. The resident is incontinent of als and is not a candidate for due to inability to control bowel to severe physical impairment. The required 2 staff assistance person assist with toileting, a briefs frequently. In the resident with the required that cognitively intact, required that cognitively intact, required the rewell and bladder. No sonoted during the assessment	F	has taken or will take the in the plan of correction. plan of correction constitu allegation of compliance. cited have been or will be date or dates indicated. F550 Dignity 1. NA #3 was removed to Resident #1 on 12/13/202 given education on custor dignity prior to returning to 2. Current Residents and 3. Current nursing staff, certified nursing assistant undergo immediate training facility specifically focused on rescommunication, privacy dicare, and responding pror lights. Education will be constant to the allowed to work undereceived. New nursing staff will received to receive the orientation produced to the plant of the plant of the orientation produced to the plant of	The following tes the facility shall deficiencies corrected by the from care of 4. NA # 3 was ner service and work. The facility shall gregarding the ent dignity, spectful curing personal inptly to call completed by the mator by shall education will call education will education will education sieve education eless by the Staff
	2:14 PM. During t that NA #3 had ch 4:30 PM. The resi knew what time it Resident #3 had h	nterviewed on 12/16/2024 at he interview Resident #3 stated langed her on 12/13/2024 at dent did not state how she was, but it was observed that her cell phone within reach. d NA #3 "seemed frustrated		4. Director of Nursing or conduct rounds to ensure responses to call lights an interactions during person to ensure dignity is maintabe completed 5x weekly x x weekly x 4 weeks, then	timely d observe al care activities ined. This will 4 weeks, then 3

Facility ID: 943091

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		345405	B. WING _			C / 23/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CO		12312024	
TVAIVIL OF T	TOVIDER OR GOLF EIER			1735 TODDVILLE ROAD	JDL		
CHARLOT	TE HEALTH & REHA	ABILITATION CENTER		CHARLOTTE, NC 28214			
(V4) ID	SLIMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 550	Continued From p	page 3	F 5	550			
	with her request r	not to use soap for urinary		weeks.			
	•	to reoccurring urinary tract		Director of Nursing or desig	nee will		
		lent #3 stated NA #3 went back		perform spot checks to asse			
	in the bathroom to	o rinse the soap out of the cloth		adhering to dignity standard			
	and slammed the	bathroom door. Resident #3		incontinent care. These aud	lits will be		
	voiced when NA #	#3 came back, NA #3 "rolled her		completed 5x weekly x 4 we	eeks, 3x		
	•	3 stated "I felt hurt, because I		weekly x 4 weeks, then wee	ekly x 4 weeks.		
		to be treated that way."					
		rted her concerns regarding NA		5. Results will be reported	,		
		rds her during 4:30 PM		Director of Nursing to the qu	-		
		to Nurse #4 around 8:45 PM. d she felt confident that Nurse		assurance meeting x1 montresolution as needed.	in for further		
		e of the situation because the		resolution as needed.			
		ys resolved issues in past in a		Date of completion			
		esident #3 stated when she		1/23/2025			
	-	ht on around 9:00 PM to receive					
		, NA #3 entered the room and					
	Resident #3 state	d she needed to be "changed."					
		rted NA #3 did not speak to her,					
	_	nt off, and exited the room.					
		d that she felt "disrespected and					
	•	is ignored and made to stay in a					
		one entered the room until NA #4					
		0:45 PM. Resident #3 stated the					
		nad soaked through her clothing, cerned about her buttocks that					
		I with barrier cream (protective					
	skin cream).	with barrier orearn (protective					
		n interview was conducted at					
		#3. NA #3 was assigned to					
		2/13/2024 during the 3:00 PM to					
		A #3 reported she provided					
		for Resident #3 once at the					
		shift around 4:45 PM. NA #3					
		she returned from her smoke 5 PM, some of her assigned					
		its were on. NA #3 stated she					
		call lights for the residents;					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	DE	12/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC 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 550	#3 reported she enter around 9:00 PM to a stated she asked Re anything, and Reside NA #3 reported she off and left the room her around 9:40 PM #3's room and the asto 7:00 AM shift wou would not be assignstated that was her f #3 and Resident #3 way" that NA #3 was she had not routinely because Resident # when she needed as On 12/18/2024 at 9: conducted with Nurs when she started he PM and completed raround 8:30 PM, Re #4 that her brief had PM and that NA #3 h like she didn't want to stated that she contaregarding NA #3 not to Resident #3. She Manager #2 around NA #3 enter Resider out and exiting the re #4 stated Unit Mana change the schedule shift and not allow N room. Nurse #4 states schedule around 10: around 9:40 PM not	t start with Resident #3. NA ered Resident #3's room inswer the call light. NA #3 esident #3 if she needed ent #3 did not say anything. turned Resident #3's call light . NA #3 stated Nurse #4 told not to go back in Resident esignment for the 11:00 PM eld be changed so that NA #3 ed to Resident #3. NA #3 irst time caring for Resident wanted things done a "certain is not aware of. NA #3 stated by rounded on Resident #3 3 was alert enough to call esistance. 43 AM an interview was is #4. Nurse #4 reported or shift on 12/13/2024 at 7:00 ounds on the residents sident #3 reported to Nurse not been changed since 4:30 nad an attitude and "acting o care for her." Nurse #4 eacted Unit Manager #2 providing incontinence care stated she contacted Unit 9:30 PM after she observed on #3's room, turning the light from around 9:00pm. Nurse ger #2 requested Nurse #4 e for the 11:00 PM to 7:00 AM A #3 back in Resident #3's	F	550			

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	I	12/23/2024	
(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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 550	provided incontinence 10:30 PM and Reside that had leaked throu to Resident #3's cloth On 12/17/2024 at 12: conducted with NA #4 #4 approached her all arrived for her 11:00 stated she and Nurse care to Resident #3 a Resident #3's clothes #4 stated Resident #3'did to make her treat On 12/17/2024 at 10: conducted with Unit M #2 stated Nurse #4 re behavior of NA #3 as providing incontinence Manager #2 stated he assignments and not Residents #3's room. that he then sent a te asking NA #3 not to reduce to her poor treatments.	e care to Resident #3 at ent #3 was soiled with urine gh the incontinence brief on ing. 00 PM an interview was 4. NA #4 stated that Nurse round 10:30 PM when she PM to 7:00 AM shift. NA #4 #4 provided incontinence round 10:45 PM and found were soaked with urine. NA 8 said, "I don't know what I me that way." 22 AM an interview was Manager #2. Unit Manager #2 being disrespectful and not be care at 9:33 PM. Unit e asked Nurse #4 to change allow NA #3 back in Unit Manager #2 reported xt to NA #3 at 9:45 PM, eturn to Resident #3's room nent towards Resident #3.	F5	550			
F 580 SS=J	#3 should have provious asked. The Administration should never feel distributed in the control of the control o	dministrator. She stated NA ded care when Resident #3 ator stated Resident #3 respected and wait until the ence care. jury/Decline/Room, etc.))(i)-(iv)(15)	F 5	80			

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F 580	consistent with his or representative(s) where (A) An accident involves results in injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-throllinical complications (C) A need to alter trea need to discontinue treatment due to advect commence a new form (D) A decision to transpect of the commence and form (D) A decision to transpect of the commence and proving the commen	ent's physician; and notify, her authority, the resident en there is- ying the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a and mental, or psychosocial reatening conditions or an existing form of erse consequences, or to enser or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ens as specified in paragraph tecord and periodically mailing and email) and	F	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345405	B. WING _			12/	23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD HARLOTTE, NC 28214	127	20/2024
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	§483.5) must disclos its physical configura locations that compripart, and must specification common changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revives Practitioner are facility failed to imme on-call Nurse Practiti Resident #1 had a signerical property of the provider that difficulty breathing. The provider that a medication for anxious documented allergy of 12/01/24 at 8:13 AM her room unresponsivital signs. Resident deceased by Emerges staff at 8:30 AM on 1 practice affected 1 of physician notification. The findings included Resident #1 was read 08/20/24 with diagnore.	istinct part (as defined in e in its admission agreement ation, including the various se the composite distinct for the policies that apply to be its different locations. This not met as evidenced ariew and interviews with staff, and Medical Director, the ediately consult with the coner on 11/30/24 when agnificant change in condition. Signs of restlessness, and to the floor and verbally at she had experienced. The facility also failed to be at Resident #1 had received the total the found in the weight of the found in the weight of the facility also failed to be at Resident #1 was found in the weight of the facility also failed to be at Resident #1 was found in the weight of the found in the weight of the facility also failed to be at Resident #1 was found in the weight of the found in the weight of the facility also failed to be at Resident #1 was found in the weight of the facility also failed to be at Resident #1 was found in the weight of the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to be at Resident #1 was found in the facility also failed to	F	580	Past noncompliance: no plan of correction required.		
	Set assessment date	#1's quarterly Minimum Data ed 11/29/24 revealed she was e resident had no behaviors					

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F 580	conducted with Nurshe had cared for Resident #3:00 PM to 7:00 very anxious when and did not eat her Resident #1 had flip and had thrown her The interview reveastay in the bed and repositioning the resident #3 breathe." NA #2 stated down, I would give I would immediately I come back saying sinterview revealed significant was told her the resident just told her the reside	ent period. 27 AM an interview was see Aide (NA) #2. NA #2 stated desident #1 on 11/30/24 during PM shift. Resident #1 was she came on shift at 3:00 PM supper meal. NA #2 recalled uped over her bedside table supper meal onto the floor. led Resident #1 would not	F 5	80			

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F 580	On 12/16/24 at 1:20 conducted with NA Resident #1 on 11/3 11:00 PM shift. She assisting Resident # because she neede anxious. NA #5 notion behavior however shall all all all all all all all all all	ge 9 and left the facility at 7:00 PM. PM an interview was #5. NA #5 was responsible for 80/24 during the 7:00 PM to stated she had a hard time #1 with incontinence care d to sit up and seemed very fied Nurse #1 of the resident's he stated Nurse #1 was w the resident was acting. At report to NA #6 and was all. During the night she saw ght on so she went back into not recall the time) to assist dent's brief. Once she lifted at #1 would not stop moving of the bed. She stated she at as best as she could but not lay down long enough, so me placing the new brief back A #5 stated she had taken before, and she had never #5 indicated she once again Resident #1 seemed very sit up and could not be still. her she was aware of the NA #5 then went back to her A AM an interview was #6. NA #6 was responsible for 80/24 during the 11:00 PM to stated at 11:00 PM she at the resident was very 1 was up and down all night in bed. During the shift she m with her because if she 1 would end up lying on the	F 5	30			

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F 580	confused. NA #6 sidifficulty breathing, want to lay down. Sit up in the bed arduring the night. Resident #1 was continued to a seem like herself. Nurse #1 was assisted to wanted to get back assisted back into	was talking but seemed tated Resident #1 was having was wheezing and did not She would assist the resident to ad sit on the side of the bed esident #1 kept saying, "Help and got Nurse #1 to go to the resident. NA #6 stated at one dishe was going to notify a diher to the hospital. However, ananged her mind and said there espital could do for the resident aware of her condition. Constantly moving from the bed fall mat during the shift, sitting Nurse #1 did not ask her to She stated she had taken care for and had never seen her in an. NA #6 stated Resident #1 as in distress. At 6:30 AM she A #1 and stated the resident and tion and did not get any ght. She told NA #1 to keep a dent #1 because she did not gned to Resident #1 on 24 during the 7:00 PM to 7:00 gnote written by Nurse #1 as a /30/24 at 8:30 PM revealed ery restless during the shift and ttempt to place herself onto the strom the wall and wrap them day parts. At 10:15 PM Resident the chair and stated she as into bed. When she was bed, she then stated she	F	580			
		on the floor. The note OM staff were sitting in the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING				23/2024
	ROVIDER OR SUPPLIER	ITATION CENTER	I	1	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD CHARLOTTE, NC 28214	120	20,202-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	on 12/01/24, Resider brief periods of time a restless again. Reside continue being restles resident back and for and to the floor per hr. 7:45 AM Resident #1 and a standing order 8:10 AM Resident #1 Emergency Medical SA nursing note writter dated 12/02/24 at 7:4 was made aware by a attempted to get out thad pulled down multiresident stated she for Resident #1's temper was provided with was to thrust herself forward was redirected and reoccurred on 11/30/24 On 12/17/24 at 3:56 If conducted with Nurse she received a report the nurse had stated down from the bed to moving around a lot. continued throughout she was not familiar was tated she didn't know to the physician becafacility. She stated she Practitioner (NP) was NP knew what was g	If for a duration of 30 Im her down. At 12:00 AM at #1 was noted to rest for and then become very ent #1 was documented to ss and staff assisted the th from the bed to the chair er request at 2:00 AM. At continued to be restless for Ativan was given. At had respiratory distress and Services (EMS) was called. In by Nurse #1 as a late entry 88 AM revealed Nurse #1 the NA that Resident #1 had of the bed several times and tiple items in her room. The left warm and thirsty. Fature decreased, and she after. Resident #1 continued and to get out of bed. She emained in bed. The incident at 9:00 PM.	F	580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			12/3	23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, C 1735 TODDVILLE RC CHARLOTTE, NC		,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH C	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 580	see the resident. Nur assumed the Nurse I Resident #1's condition was baseline. She stated physician in the morr middle of the night. It shift would tell them. A nursing note writted dated 12/02/24 at 8: was made aware by was in possible distre NA #1 after medication entering the room, this low to respond. Nur and to call emergence #1's vital signs were (normal blood pressument of the properties of the pr	rse #1 stated because she Practitioner was aware of on and wasn't concerned, as probably the resident's "I would rather talk to the ning than at 3:00 AM in the seems like something day	F	580				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING			1	C 23/2024	
	ROVIDER OR SUPPLIER			1735 TODD	DRESS, CITY, STATE, ZIP CODE VILLE ROAD ITE, NC 28214	<u> 121</u>	23/2024	
(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)		(X5) COMPLETION DATE	
F 580	with her to see what stated Resident #1 wout of the bed and version and the Alivan work on-call physician bed #1 had a diagnosis of excited" like most result and the Ativan would a nursing note writte 12/01/24 at 12:14 PM had received report of Resident #1 was result attempted to get out throughout the night. #2 the resident was assessment Resident (low levels of oxygent of 60% (normal level of supplemental oxygent of 60% (normal level of 50% (no	she could do. Nurse #3 yas screaming out, crawling ery anxious. At approximately gain came to her and stated at to do with Resident #1. yruct Nurse #1 to notify the cause she felt that Resident of COPD and was "just sidents with the diagnosis I help calm her. In by Nurse #2 dated of as a late entry revealed she of yrom Nurse #1 who stated teless all evening and of bed multiple times Nurse Aide #1 alerted Nurse unresponsive. Upon at #1 was noted to be hypoxic by with an oxygen saturation greater than 92%) on 4 liters gen via nasal cannula. Services (EMS) was notified,	F	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 2/23/2024	
	NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		21201202-	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	#3 and Unit Manage Ativan from the Armedication manage #1 while Nurse #2 began to start her #1 then brought he it for Resident #1 at the medication. Not any questions or le prior to administer with the resident of medication around the resident's room floor on her fall material material material was in the resident drank was the room. She was approximately 5-1 was wrong with Reference with the bed with he open and a faint popen and a faint	age 14 ad at the nurses station. Nurse ger #1 then went to pull the a automated system for gement machine for Resident finished getting report and medication pass. Unit Manager er a cup with a 0.5 mg Ativan in and stated to her to administer urse #2 stated she did not ask book at the resident's allergies ing the Ativan 0.5 mg along of Resident #1's morning d 7:44 AM. When she went into m, she was sitting up on the at. Nurse #2 and NA #1 ent to get up to the side of the edication. Nurse #2 medication and stated the ter provided and Nurse #2 left so then alerted by NA#1 0 minutes later that something esident #1. Nurse #2 and Nurse esident's room to find her lying er eyes open and fixed, mouth ulse. EMS were called and vital ed. Nurse #2 stated Resident ed deceased by EMS at 8:30 :07 PM an interview was urse Aide (NA) #1. During the ed she came on shift around /24 to find Resident #1 lying on floor. Resident #1 looked at NA an't take this no more". She who told her not to get the or because she had been back bed to the floor all night. NA #1 did not feel comfortable leaving	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILD			، ا	C
		345405	B. WING				23/2024
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
				17	735 TODDVILLE ROAD		
CHARLO	TTE HEALTH & REHAB	ILITATION CENTER		С	HARLOTTE, NC 28214		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	since she was want proceeded to clean her brief while she was the was the proceeded to clean her brief while she was the massisted Resident when was tangled. The resident when was tangled the resident when was to take her back to the resident want to take her back to the resident was to the resident was the mangle the resident was the mangle the resident was the mangle of the was the manager on the 7:00 AM to 7:00 revealed she arrived AM and noticed Resident	ge 15 In her fall mat in the floor but ing to be on the fall mat she Resident #1 up and change was lying on the fall mat. NA esident #1 up to the side of her ing her oxygen tubing cord. NA #1 was in the room with durse #2 entered the room and sident's medication around ind Resident #1 acted like she in the medication, but she had dent untangling oxygen tubing. The room as NA #1 continued dent's oxygen tubing cord. NA esident call out her name. Found Resident #1 was lying in her eyes fixed up at the pen. Resident #1 would not she yelled out for Nurse #2 way outside of the resident's I with the resident until Nurse intered the room. Nurse #1 was son the resident to try and get ever she did not. EMS was in the resident's care once they she had taken care of the prior on 11/30/24 during the shift and she was in no of anxious during the shift. 19 AM an interview was in Manager #1. During the interest in the shift. 19 AM an interview was in Manager #1. During the interest in the shift. 19 AM an interview was in Manager #1. During the interest in the shift. 19 AM an interview was in Manager #1. During the interest in the shift. 19 AM an interview was in Manager #1. During the interest in the shift. 19 AM an interview was in Manager #1. During the interest in the shift. 19 AM an interview was in Manager #1. During the interview in the facility around 7:12 interest in the was in the facility around 7:12 interest in the was in the facility around 7:12 interest in the was in the was in the facility around 7:12 interest in the was in the facility around 7:12 interest in the was in the was in the facility around 7:12 interest in the was in the was in the facility around 7:12 interest in the was in the was in the facility around 7:12 interest in the was in the was in the was in the facility around 7:12 interest in the was in the was in the was in the facility around 7:12 interest in the was in the was in the was in the facility around 7:12 interest in the was in the facility around 7:12 interest in the was in the faci	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/23/2024	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 580	#1 stated it was the could be. She was to very restless, agitate herself out of bed du notified by a Nurse Arecall) that Resident was a DNR, so she Nurse #1, Nurse #2 the resident. EMS hand were enroute to to print the resident's DNR pto the facility. EMS records dated notified at 8:13 AM, 8:18 AM, arrived on resident at 8:30 AM cardiac/ respiratory. Resident #1 was for was apneic (without Resident #1 had no not resuscitate orde pronounced deceased on 12/16/24 at 2:24 conducted with the form on 12/01/24 to nexpired. The nurses did not notify the onhad experienced a castated all nurses invithe facility protocol in a change of condition.	safest place the resident old Resident #1 had been ed and had been throwing uring the night. She was then Aide (name she could not #1 was coding. Resident #1 went to the room to find and NA #1 in the room with ad already been contacted the facility. She left the room is paperwork and gave EMS paperwork upon their arrival 12/01/24 revealed they were dispatched to the facility at scene at 8:29 AM and to the with a chief complaint of arrest. Upon EMS arrival and lying in bed. The resident breathing) and pulseless. heart tones with a valid do r (DNR). She was	F 5	580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTR NG		(X3) DATE COMP	SURVEY LETED
		345405	B. WING _				23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		1735 TODE	DDRESS, CITY, STATE, ZIP CODE DVILLE ROAD TTE, NC 28214		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Ativan 0.5 mg to Rerestlessness and ag administered Ativan and Resident #1 wa with a low oxygen sa called to the facility, pronounced as deceromer Director of Nate documentation, a suspended the nursi investigation into the responsible for the nation of the incident notified had experienced differ increased anxiety. On 12/16/24 at 1:34 conducted with the conducted on 11/30/2 Resident #1. She state because the facility anything acute happ having trouble breat immediately sent the an evaluation. On 12/16/24 at 1:38 conducted with the National Management on 12 administered Ativan documented allergy	of AM, Nurse #2 administered sident #1 due to behaviors of itation. Nurse #2 to Resident #1 at 7:44 AM is then found unresponsive aturation level. EMS was and the resident was eased. At 11:30 AM the dursing (DON) was reviewing and they immediately es involved and completed an exincident. Nurse #1 was esident during the 7:00 PM to ad needed guidance from er about the standing order one of the 4 nurses involved in a provider that Resident #1 ficulty breathing, restlessness on-call Nurse Practitioner. She stated she was not 24 or 12/01/24 regarding ated that was unusual typically would let her know if bened but if a resident was hing, she would have exercised to the hospital for PM an interview was Medical Director (MD). The notified him of an incident 2/01/24 when a nurse to a resident with a to the medication. The ne first time he was contacted	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING		C 12/23/2024	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	12/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 580	Resident #1 had excondition starting a 11/30/24. The MD s Practitioner would happened after 5:0 facility should have hospital for an eval the nursing progrese episode and could dioxide (A waste progressed and could dioxide	and occurred. He wasn't notified operienced a change of the approximately 3:00 PM on stated the on-call Nurse have been notified if it 0 PM. The MD stated the sent Resident #1 to the unation because from review of sent sent sent and a respiratory have had increased carbon oduct produced during ansported through the lungs, where it is exhaled as and estated the result of els would be psychotic etting up and down out of bed in. The MD stated if they had be Practitioner, she would have the hospital for an evaluation in the was likely having an acute open as she had experienced in the dot be on a BiPap lation therapy). In the wasn't notified of the immediate 24 at 6:30 PM. In the dot of the immediate of the following corrective completion date of 12/07/24.	F 58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/23/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/23/2024
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F 580	expressed to staff the difficulty breathing. A noted in her room un pressure of 94/60, prate of 4 and oxygen staff applied a non-remergency Medical #1 was pronounced 8:30 AM. Address how the fact residents having the the same deficient portion of the same deficient practice will be same deficient practice will be same deficient of the same deficient of	at she was experiencing at 8:13 AM Resident was been responsive with a blood alse rate of 111, respiratory a saturation level of 54%. The elbreather mask then called Services (EMS). Resident deceased by EMS staff at decea	F 58	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/23/2024	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		•	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	education during the of Nursing ensured medication aides we their next scheduled Director of nursing assistants on verbal in condition such as abnormal behaviors the nurse for assess All nursing note reviews were composed changes in covitals taken and phyreviews will be composed changes in covitals taken and phyreviews will be composed changes in covitals taken and phyreviews will be composed changes in covitals taken and phyreviews will be composed composed in condition or Designe weeks. New changes in covital to the nursing clinical meetings for any not physician notification and is ongoing as a condition from the vote the nursing clinical clinical meeting. The	ge 20 tion aides will receive e orientation process. Director all licensed nurses and ere educated prior to working d shift as of 12/6/2024. reeducated all certified nursing illy reporting any noted change is altered mental status, is, abnormal vital signs, etc. to sment as of 12/6/2024. riews, and 24-hour reports leted by the Director of e by 12/06/2024 to ensure ondition were addressed, ysician notified. Nursing note repleted by the Director of e on 5 residents weekly x 12 reditions will be reviewed by team during morning clinical on. This occurs 5 times weekly of 12/06/2024. New changes in weekend will be reviewed by team during the Monday e nursing team was notified of in 12/3/2024 by the facility	F 58	30			
	performance to mai sustained; As of 12/3/2024 the	cility plans to monitor its ke sure that solutions are e results of the monitoring will					
	Nursing in the weel	Administrator or Director of kly Risk meeting and during Assurance Performance					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345405	B. WING			C 2/23/2024
ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	<u> </u>	L(LO) LOL4
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
Improvement (QAPI) Interdisciplinary Team 3 months. Changes we necessary to maintain safety. The IDT team Administrator, Director, Social Work Minimum Data Set (Mainimum Data Set (Main	meeting with the n (IDT) as of 12/03/2024 for will be made to the plan as n compliance with resident will consist of the or of Nursing, Medical her, Activities Director and MDS) nurse. Iliance and the immediate le is 12/07/2024. The ective action plan was reification through facility interviews revealed all leived education on the land physician notification condition to include providing resments, that required tain vital signs, signs of n, oxygen saturations, and here is notification to the nursing ident with a change of 's in-service log, monitoring material was reviewed.	F 58			
the corrective action Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria	plan was validated. Neglect m Abuse, Neglect, and right to be free from abuse, ation of resident property,	F 60	00		
	ROVIDER OR SUPPLIER TE HEALTH & REHABIL SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page Improvement (QAPI) Interdisciplinary Team 3 months. Changes v necessary to maintain safety. The IDT team Administrator, Directo Director, Social Work Minimum Data Set (N Alleged date of comp jeopardy removal dat On 12/23/24, the corn validated by onsite ve staff interviews. The nursing staff had rece change in condition a related to change in c comprehensive asses medical attention, ob restlessness, agitatio any breathing issues interviewed regarding staff if they see a resi condition. The facility results and training m The immediate jeopa 12/07/24. The compl the corrective action Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of compliance and the immediate jeopardy removal date is 12/07/2024. On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on the change in condition and physician notification related to change in condition to include providing comprehensive assessments, that required medical attention, obtain vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues. Nurse Aides were interviewed regarding notification to the nursing staff they see a resident with a change of condition. The facility's in-service log, monitoring results and training material was reviewed. The immediate jeopardy was removed on 12/07/24. The completion date of 12/07/24 for the corrective action plan was validated. Free from Abuse and Neglect CFR(s): 483.12(a)(1)	ROVIDER OR SUPPLIER THE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of compliance and the immediate jeopardy removal date is 12/07/2024. On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. 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Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	ROVIDER OR SUPPLIER THE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 21 Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of compliance and the immediate jeopardy removal date is 12/07/2024. On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. 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CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	THE HEALTH & REHABILITATION CENTER THE HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPCEMENT WAITS THE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 21 Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of compliance and the immediate jeopardy removal date is 12/07/2024. On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. 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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600		ge 22 mited to freedom from i, involuntary seclusion and	F 6	500		
	treat the resident's n					
	physical abuse, corpinvoluntary seclusion This REQUIREMEN by: Based on record repractitioner (NP), an interviews, the facilit #1's right to be free failed to: 1) immedia Nurse Practitioner on had a significant chasion PM to 11:00 PM restlessness, agitation and verbally express difficulty breathing; 2 assessments for the continued through the deliberately dismedical record (EMI (a benzodiazepine, undication) was entadministered to a redocumented allergy the physician that At resident with a docurecognize the serious in condition and ider medical attention. Owere contacted whe	se verbal, mental, sexual, or poral punishment, or n; T is not met as evidenced view, and facility staff, Nurse and Medical Director (MD) y failed to protect Resident of neglect when the facility tely consult with the on-call in 11/30/24 when a resident ange in condition during the M shift that included signs of con, crawling onto the floor sing to staff that she had 2) complete ongoing thorough change in condition that the 11:00 PM to 7:00 AM shift; and medication error when regarded an electronic R) system alert when Ativan used as a sedative erred into the EMR and		Past noncompliance: no plat correction required.	n of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 2/23/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•	212312024	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	pulseless and Resid deceased at 8:30 AM affected 1 of 3 samp neglect (Resident #1 The findings include This tag is cross reference to the findings include This tag is cross reference to the findings include This tag is cross reference to the findings include This tag is cross reference to the findings include This tag is cross reference to the findings include This tag is cross reference to the finding include to the finding include the to the finding include the finding incl	neic (without breathing) and ent #1 was pronounced M. This deficient practice pled residents reviewed for h.). d: erenced to: ord review and interviews with the precipied consult with the grid and precipied in condition. It is gins of restlessness, that the floor and verbally at she had experienced at Resident #1 had received it is for which she had a con 12/01/24 at 7:44 AM. On Resident #1 was found in the with seriously abnormal at #1 was pronounced ency Medical Services (EMS) 12/01/24. The deficient for a resident #1). ervations, record review, and the Practitioner (NP), and on interviews, the facility failed sness of a significant change	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 600	verbally expressed to During the night shift difficulty breathing, a continued and Resid to help her. On 12/0 was noted in her roo pressure of 94/60, prate of 4 and oxygen Resident #1 was proceed Emergency Medical AM. This deficient proceed and the sampled residents resident #1). F760: Based on recount staff, Medical Desident #1). F760: Based on recount staff, Medical Desident #1 facility failed to prevee the room of the electronic of the electronic of the electronic order due to the allest and entered the was then pulled from medication manager was orienting under Manager, administer 12/01/24 at 7:44 AM Resident #1 became abnormal vital signs. pronounced decease Services (EMS) staff.	d, crawling onto the floor and o staff she could not breathe. It (11:00 PM to 7:00 AM) the anxiety and agitation lent #1 asked staff repeatedly 11/24 at 8:13 AM Resident of unresponsive with a blood culse rate of 111, respiratory is asturation level of 54%. In ounced deceased by Services (EMS) staff at 8:30 rectice occurred for 1 of 3 reviewed for quality of care ordered and pharmacist, the rent a significant medication with received a dose of Ativan used as a sedative restime dose. Resident #1 had documented on the Allergy medical record (EMR) on record by Nurse #3. She medical record flagged the regy, but she "bypassed" the regy, but she "bypassed" the responsive with seriously an automated system for ment. Nurse #2, a nurse who the supervision of the Unit red the medication on . On 12/01/24 at 8:13 AM a unresponsive with seriously resident #1 was red by Emergency Medical at 8:30 AM. This deficient of 1 of 3 sampled residents	F	600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345405	B. WING _				C / 23/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 12/	23/2024	
				173	35 TODDVILLE ROAD			
CHARLOT	TE HEALTH & REHABIL	LITATION CENTER		CHARLOTTE, NC 28214				
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F 600	Continued From pag	e 25	F	600	· · · · · · · · · · · · · · · · · · ·			
	1 3							
	The Administrator wa jeopardy on 12/17/24	as notified of the immediate at 6:30 PM.						
		the following corrective mpliance date of 12/07/24.						
	Address how correct accomplished for tho been affected by the	se residents found to have						
	for Resident #1's allea a one-time dose on 1 the order for Ativan a the order due to a do Resident #1, Nurse # continued to enter the pulled from the Omni #1 on 12/01/24 at ap approximately 8:15 A her room unresponsi 94/60, Pulse: 111, Resaturation level of 54 Services (EMS) was Resident #1 decease failed to provide comfailed to identify a signatural signs and ongoin the evening and night 12/01/24. On 11/30/2	It to act upon the system alert ergy to Ativan when ordering 12/01/24. Nurse #3 entered and when the system flagged ocumented allergy for 13 "by passed" the alert, to order which was then icell and given to Resident proximately 7:35 AM. At 14 AM Resident #1 was found in the we with vital signs: b/p: espirations: 4, Oxygen 9%. Emergency Medical called and pronounced and at 8:30 AM. The facility prehensive assessments, inificant change in condition attention, failed to obtain and oxygen saturations during to n 11/30/24 through 14 during the 3:00 PM to the state of the system of the sys						
	restlessness, agitatic and verbally express experiencing difficulty from 11:00 PM to 7:0 notify the on call med	on, crawling onto the floor ed to staff that she was y breathing which continued 0 AM. The facility failed to dical provider that a resident nange of condition on						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345405	B. WING		C 12/23/2024
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	12/20/2021
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 600	notified at 11:13 am had an allergy to At incident were susper investigation. Nurse terminated and repras of 12/4/2024. Nu letter on 12/7/2024 terminated and app was brought back of the training prograr immediately on 12/notified of Resident medication allergy a 12/01/2024 by the I Practitioner was no change in condition. Address how the faresidents having the same deficient. Current residents a An audit of medication and physical electronic medical in Director of Nursing ensure that medicate the listed allergies. An audit on 12/3/20 of Nursing and designated the listed allergies.	Director of Nursing was a by Nurse #1 that Resident #1 tivan. Nurses involved in the ended on 12/1/2024 pending #1, and Nurse #3 were orted to the Board of Nursing urse #2 turned in a resignation. The Unit Manger was initially realed the termination. She on 12/16 and placed back into m. She resigned effective 28. Medical Director was as #1 change in condition and that around 1:00 pm on Director of Nursing. The Nurse tified around 8:30 AM of a mand an allergy to Ativan.	F 600		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345405	B. WING			1	C 23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		173	REET ADDRESS, CITY, STATE, ZIP CODE 85 TODDVILLE ROAD IARLOTTE, NC 28214	1 12/	20/2027
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Audits included all c affected by this defic reviewed to ensure a physician notification allergy alert which w reviewed by the dire	urrent residents who could be cient practice of neglect were any change in condition and as well as bypassing the could result in neglect were ctor of nursing. No negative ring the audit on 12/3/2024.	F	600			
	systemic changes medicient practice will be deficient practice will be deficient practice will be deficient practice will be deficient practice. The property in regard to also acknowledgement of included physician in bedden by definition of the property of the characteristic property of the property o	ures will be put into place or lade to ensure that the I not recur; If the Director of Nursing on pocess for medication order ents related to allergies and falerts. Education also otification of known allergies. If the Director of Nursing on large in condition and comprehensive assessments attention, obtaining vital essness, agitation, oxygen breathing issues and lian of change in condition. It ded the documentation of essment into the electronic					
	Education also addr processes results in abuse. Director of nursing e	essed failure to follow above neglect which is a form of ducated all certified nursing ng any noted change in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345405	B. WING				C / 23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, 1735 TODDVILLE F CHARLOTTE, NO			20/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	of 12/6/2024. Any licensed nurse receiving this educated until receiving the educated prior scheduled shift as on the view of the orientation proceduntil a Staff Development of the Director of Nursing 12/06/2024 to ensure related to a resident observations will be Nursing or Designer medication aides were weekly and is ongoinallergy alerts will be All nursing notes an reviewed by the nurmorning clinical medication to ensure the condition to ensure the condition to ensure the condition of the condition of the condition to ensure the condition of the	and medication aides not tion will not be able to work ducation. Director of Nursing nurses and medication aides to working their next of 12/6/2024. Is will receive education during tess by the Director of Nursing ment Coordinator is hired. Itions on current licensed fon aides will be completed by the no medications are given allergy. Med pass completed by Director of the on 5 licensed nurses and/or	F	600	BEHOLINGTY		
	12/06/2024. Directo review nursing note any change in condi	weekly and is ongoing as of r of Nursing or designee will s over the weekend to ensure tion is addressed. Nursing completed by the Director of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED		
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	20//255 05 0//25//55	345405	B. WING _	0.70.55		12/	23/2024
	ROVIDER OR SUPPLIER TE HEALTH & REHABIL	ITATION CENTER		1735 TO	r address, city, state, zip code DDDVILLE ROAD LOTTE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	Continued From page	e 29	F 6	600			
	Nursing or Designee weeks.	on 5 residents weekly x 12					
	12 weeks to ensure the change in condition to	w 5 nurse aides weekly for					
	the Director of Nursin training on abuse and then quarterly ongoin abuse and neglect is federal guidelines, "N "the failure of the faci providers to provide g	g will complete monthly I neglect for 3 months and g. Education will ensure explained to all staff per eglect" as defined at 483.12, lity, its employees or service goods and services to a essary to avoid physical					
		ity plans to monitor its sure that solutions are					
	be reviewed by the Ad Nursing in the weekly the monthly Quality A Improvement (QAPI) Interdisciplinary Team 3 months. Changes w necessary to maintain safety. The IDT team Administrator, Director	n (IDT) as of 12/03/2024 for will be made to the plan as a compliance with resident will consist of the por of Nursing, Medical er, Activities Director and MDS) nurse.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	!	12/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	DATE	
F 684 SS=J	validated by onsite vestaff interviews. The nursing staff had receprocess for medication alerts related to allerg of alerts. Education anotification of known included change in coproviding comprehen require medical attensigns of restlessness saturations, and any also included the docomprehensive assessmedical record. Education follow above process which is a form of abinterviewed regarding staff if they see a resicondition. The facility results and training materials and training materials. The immediate jeopa 12/07/24 and the contractive action Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a further applies to all treatment facility residents. Bas assessment of a residents received accordance with professions.	rective action plan was erification through facility interviews revealed all eived education on the on order entry in regard to gies and acknowledgement Iso included physician allergies. The education also ondition and included sive assessments that tion, obtaining vital signs, agitation, oxygen breathing issues. Education rumentation of essment into the electronic reation also addressed failure resses results in neglect ruse. Nurse Aides were gonotification to the nursing ident with a change of its in-service log, monitoring reaterial was reviewed. Try removal date of appliance date of 12/07/24 for plan were validated. The plan were validated. The plan were validated to red on the comprehensive dent, the facility must ensure a treatment and care in ressional standards of the nersive person-centered.		684			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD	NG _		، ا	С
		345405	B. WING				23/2024
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHARL OT	TE HEALTH & REHABI	I ITATION CENTER		17	735 TODDVILLE ROAD		
OHARLOT	TE TIERETT & RETIRET	ENATION CENTER		С	HARLOTTE, NC 28214		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, Nurse Practitioner (NP), and			684	Past noncompliance: no plan of correction required.		
	Medical Director (MI to identify the seriou in condition, comple assessments and id medical attention for chronic obstructive preported she could reduring the 3:00 PM to was restless, agitate verbally expressed to During the night shift difficulty breathing, a continued and Resict to help her. On 12/0 was noted in her roopressure of 94/60 (n 120/80), pulse 111 (respiratory rate 4 (not and oxygen saturation level great was pronounced dec Medical Services (E deficient practice occidence assessments and identification of the serious continued and services (E deficient practice occidence assessments and identification of the serious continued and services (E deficient practice occidence assessments and identification of the serious continued and services (E deficient practice occidence assessments and identification of the serious continued and serio	D) interviews, the facility failed sness of a significant change te ongoing thorough entify the urgent need for a resident with a history of oulmonary disease who not breathe. On 11/30/24 to 11:00 PM shift, Resident #1 ed, crawling onto the floor and to staff she could not breathe. It (11:00 PM to 7:00 AM) the					
	Resident #1 was rea 08/20/24 with diagno pulmonary disease (The findings included: Resident #1 was readmitted to the facility on 08/20/24 with diagnoses of chronic obstructive pulmonary disease (COPD) and respiratory					
		was 67 years old. electronic medical record 8/20/24 included the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN C X (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA		
F 684	A physician order da Resident #1 required oxygen via 2 liters/m saturation levels gre A physician order da Resident #1 was preinhalation nebulization treatment) to inhale a day related to COFA review of Resident Set assessment date cognitively intact. The during the assessment received antianxiety	esident #1's allergy reaction unspecified. ted 08/20/24 revealed continuous supplemental inute to maintain oxygen	F	DEFICIEI 684	NCY)		
	was conducted with stated she had cared during the 3:00 PM to was very anxious where PM and did not eat here alled Resident #1 table and had thrown floor. The interview mot stay in the bed a repositioning the result because Resident #1 breathe." NA #2 statedown, I would give here would immediately here come back saying sl	AM a telephone interview Nurse Aide (NA) #2. NA #2 If for Resident #1 on 11/30/24 If o 7:00 PM shift. Resident #1 If then she came on shift at 3:00 If the supper meal. NA #2 If the had flipped over her bedside in her supper meal onto the evealed Resident #1 would ind NA #2 had to keep ident so she was sitting up if said to her, "I can't ted, "I sat her up to calm her er the call light and she if the light again asking me to the couldn't breathe." NA #2 If the said to her in the light again asking me to the couldn't breathe." NA #2 If the said to her in the light again asking me to the couldn't breathe." NA #2 If the said to her in the light again asking me to the couldn't breathe." NA #2 If the said the s					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345405	B. WING			C 12/23/2024		
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	CODE	12/20/2027		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	The state of the s	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 684	her the resident was continued to use her and if she did not car door stating, "I can't #2 had not cared for and was not familiar that was typically ho Resident #1 was we during the shift. NA # continued to be anxi throughout her shift the oncoming NA (NA A nursing note dated documented by Nursivital signs taken on blood pressure 135/67, respiratory rate 1 was receiving oxyge minute. No signs or moted. On 12/16/24 at 12:30 was conducted with interview she stated Resident #1 on 11/37:00 PM shift. Nurse seemed fine during the anxious or short of b #2 coming to her and eaten her supper me bedside table. Nurse Resident #1 yell out during the shift. Nurse	on; however they just told anxious. Resident #1 call light throughout the shift II out, she would yell out the breathe, I can't breathe." NA Resident #1 prior to that day with the resident to know if w Resident #1 acted. aring supplemental oxygen #2 stated Resident #1 ous and have behaviors and reported the behaviors to A#5). I 11/30/24 at 6:39 PM se #2 revealed Resident #1's 11/27/24 with readings of 72, temperature 97.6, pulse 14 and O2 96%. Resident #1 in therapy at 2 liters per symptoms of distress were O PM a telephone interview Nurse #2. During the she had taken care of 0/24 during the 7:00 AM to #2 stated Resident #1 in the shift and did not seem reath. She did not recall NA did stating the resident had not seal or thrown over the #2 did not recall hearing that she could not breathe	F	684				
	5:00 PM and she wa	s able to swallow her not seem to be in any eport to Nurse #1 that						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			1	22/2024
NAME OF D	ROVIDER OR SUPPLIER	0.10.100		9-	TREET ADDRESS, CITY, STATE, ZIP CODE	121	23/2024
NAME OF T	TOVIDEN ON 3011 LIEN						
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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 684	Continued From page	e 34	F	684			
F 684	Resident #1 was usin but the nurses said the resident. Nurse #2 in 7:00 PM. Nurse #2 stable facility and was not well as facility and was were don 11/30/24 during the massible for Resident #1 was conducted with measurements for Resident #1 was very difficulty breathing. Note that the second anxious. NA #5 notification behavior around 10:00 Nurse #1 was already was acting because so the room during the second gave report to NA #6 #5) was assigned to a (could not recall what #1's call light on so so to assist NA #6 with conce she raised the not stop moving and stated she cleaned the stop moving and stated she cleaned the not stop mov	ng her call light repeatedly, nat was normal for the dicated she left the facility at ated she was new to the ery familiar with Resident #1. Et's medical record revealed ocumented for Resident #1 to 7:00 PM shift. PM a telephone interview NA #5. NA #5 stated she was ent #1 on 11/30/24 during PM shift. NA #5 indicated from NA #2 who had stated		684			
	enough, so she had a new brief back onto t she had taken care o she had never been t wearing supplementa	a difficult time placing the he resident. NA #5 stated f Resident #1 before, and hat way. Resident #1 was all oxygen during the shift. NA e again let Nurse #1 know					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING _				C 23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER		1735 TOD	DDRESS, CITY, STATE, ZIP CODE DVILLE ROAD DTTE, NC 28214	1 12/	23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 35	F	84				
	up and could not be she was aware of the then went back to he	· ·						
	was conducted with for Resident #1 on 1 to 7:00 AM shift. She	AM a telephone interview NA #6 who was responsible 1/30/24 during the 11:00 PM e stated at 11:00 PM she that the resident was						
	very anxious. Resident and would not she sat in the room was a second to the room was a second t	ent #1 was up and down all stay in bed. NA #6 recalled with Resident #1 during the didn't then Resident #1 would						
	end up lying on the f but seemed confuse was having difficulty	loor. Resident #1 was talking d. NA #6 stated Resident #1 breathing, was wheezing and						
	resident to sit up in t the bed during the ni "Help me" so she we	own. She assisted the he bed and sit on the side of 19ht. Resident #1 kept saying, ent and got Nurse #1 to go to						
	what time). Nurse #1 looked at Resident #	ne resident (could not recall went into the room and and said she was going to d send her to the hospital.						
	mind and said there could do for the resid	er Nurse #1 changed her was nothing the hospital dent because they were						
	fall mat during the sh Resident #1 was we	om the bed to the floor on her nift, sitting up on the fall mat. aring supplemental oxygen						
	obtain vital signs, so stated she had taker	se #1 did not ask her to she did not get them. She n care of Resident #1 before her in the state she was in,						
	AM she gave a repo	ne was in distress. At 6:30 rt to NA #1 and stated the ge of condition and did not						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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F 684	Continued From pa	ge 36	F	684		
		g the night. She told NA #1 to n Resident #1 because she did lf.				
	revealed an order for (breathing treatment at bedtime related to Pulmonary Disease 11/30/24 the medica PM. Nurse #1 docu 9:00 PM dose. Revithe bottom of the M	ord dated November 2024 or nebulization solution t) to inhale orally via nebulizer o Chronic Obstructive with Acute Exacerbation. On ation was scheduled for 9:00 mented a (2) for the 11/30/24 lew of the legend located at AR dated November 2024 ation of a (2) meant the				
	12/02/24 obtained by assigned Resident: AM shift on 11/30/2 statement revealed of the bed and layin Nurse #3 asked her available and Nurse Was then told by orders for Ativan, an automated medicati #1 was unable to a medication dispens until the next shift gave report to Nurse after Nurse #3's me something was wro asked if she would support, so Nurse # resident's room Resident and support in the state of t	and signed by Nurse #1 on by the facility revealed she was #1 during the 7:00 PM to 7:00 4 through 12/01/2024. The Resident #1 kept getting out go not the floor during the shift. If the resident had any Ativan at #1 stated she wasn't sure. The facility had standing and it could be pulled from the ston dispensing system. Nurse cocess the automated ing system and had to wait to be able to obtain the Ativan. Farrived at 7:00 AM Nurse #1 arrived in pass and stated ing with Resident #1. Nurse #3 go to the resident's room for 1 did. Upon arrival to the sident #1 was face up, lying in ponse to communicate. She				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	ODE	12/23/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 37	F	684		
	asked for vital signs after feeling a weak #1 continued to do a until EMS arrived. A told Resident #1 had and that she had an Nurse #1 noted in hadminister the medithe resident's MAR responsible for the floor and pull cords around various body #1 was assisted to the wanted to get back signs completed WN When she was assistated she wanted to room with Resident minutes to try and con 12/01/24, Reside brief periods of time restless again. Resident back and for and to the floor per 7:45 AM (12/01/24) restless and a stand given. At 8:10 AM Figure 1.	and for someone to call EMS pulse on the resident. Nurse a sternal rub on the resident after EMS arrived, she was dexpired. Nurse #1 was latered received by mouth Ativan allergy to the medication. Her statement she did not cation but had signed off on because she was the nurse resident and had initiated the states are also and the medication. In through 12/1/2024 at 7:00 written by Nurse #1 as a late 4 at 8:30 PM revealed ry restless during the shift and the chair and stated she into bed. The note read, "vital NL (within normal limits)". In the chair and stated she into bed. The note read, "vital NL (within normal limits)". In the day staff were sitting in the staff or a duration of 30 alm her down. At 12:00 AM and then become very dent #1 was noted to rest for and then become very dent #1 was documented to be said and the staff assisted the orth from the bed to the chair the request at 2:00 AM. At Resident #1 continued to be ling order for Ativan was Resident #1 had respiratory ency Medical Services (EMS)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
	345405	B. WING _			C 12/23/2024
NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABIL	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	DE	.==0.=0
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	
dated 12/02/24 at 7:4 was made aware by attempted to get out pulled down multiple resident stated she fe Resident #1's tempe was provided with wa to thrust herself forwa was redirected and re occurred on 11/30/24 A nursing note writter for 12/01/24 dated 12 Nurse #1 was made Resident #1 was in p discovered by NA #1 administration. Upon resident was face up #1 requested vital sig medical services. Re blood pressure 94/60 reading 120/80), puls 60-100), respiratory i rate 12-20) and oxyg (normal oxygen satur 92%), Nurse #1 cont name with no respon oxygen saturation lev saturation reading of oxygen (amount uns) scene and were able care. On 12/17/24 at 3:56 was conducted with I	n by Nurse #1 as a late entry 48 AM revealed Nurse #1 the NA that Resident #1 had of bed several times and had items in her room. The elt warm and thirsty. rature decreased, and she ater. Resident #1 continued ard to get out of bed. She emained in bed. The incident 4 at 9:00 PM. In by Nurse #1 as a late entry 2/02/24 at 8:10 AM revealed aware by Nurse #2 that bossible distress after being	F6	984		

· ,		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/23/2024	
	ROVIDER OR SUPPLIER	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	·		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	shift. Nurse #1 state from Nurse #2 at 7: had stated the residence the bed to the floor around a lot. Nurse behavior continued entire shift. Nurse # with the resident. Not the process for notion because she was in the building was going on with a back in the facility to resident. Nurse #1 the Nurse Practition #1's condition was probed. Nurse #1, who was facility, stated she was tatement to the fact more questions ask. On 12/16/24 at 12:0 conducted with Nurse was tated. On 12/16/24 at 12:0 conducted with Nurse fall mat in the floor via nasal cannulation.	or the 7:00 PM to 7:00 AM ed when she received a report 00 PM on 11/30/24 the nurse dent was up and down from very anxious and moving #1 recalled the anxious throughout the night for her ed said she was not familiar urse #1 stated she didn't know fication to the physician ew to the facility. She stated a Nurse Practitioner (NP) daily that the NP knew what Resident #1 and would be the next day to see the stated because she assumed there was aware of Resident wasn't concerned, then the tably the resident's baseline. The no longer employed by the vanted to use her initial cility as a response to any ted. The PM an interview was see Aide (NA) #1. During the dishe came on shift around the to find Resident #1 lying on the proof of the proof	F 68				
	went to Nurse #1 w resident off the floo and forth from the b told Nurse #1 she of the resident lying of since she was want proceeded to clean	n't take this no more". She ho told her not to get the r because she had been back bed to the floor all night. NA #1 lid not feel comfortable leaving n her fall mat on the floor but ting to be on the fall mat she Resident #1 up and change was lying on the fall mat. NA					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 2/23/2024	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•	1 12/20/2024	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	bed and began fix which was tangled the resident when administered the resident when heard the resident with her heard the resident with her mouth operation of the pack with her with her mouth operation. NA #1 stays #1 and Nurse #2 doing a sternal rule her to respond, he called and took of arrived. She state Resident #1 the dotated 7:00 AM to 3:00 F distress and was an undated After-Orders revealed fibehavior the nursimilligram (mg) by the action in 20 m respond to the menotify the primary further orders. A medication adminedical record darevealed Nurse #3 oral tablet 0.5 mg time only related the exacerbation. The alert for a system	Resident #1 up to the side of her king her oxygen tubing cord d. NA #1 was in the room with Nurse #2 entered the room and resident's medication. NA #1 sident call out her name. When d Resident #1 was lying flat on eyes fixed up at the ceiling and ben. Resident #1 would not on she yelled out for Nurse #2 allway outside of the resident's ed with the resident until Nurse entered the room. Nurse #1 was be on the resident to try and get owever she did not. EMS was were the resident's care once they did she had taken care of any prior on 11/30/24 during the PM shift and she was in no not anxious during the shift. Hours Standing Physician or aggression or agitated the may administer Ativan 0.5 mouth. The nurse could repeat inutes if the resident did not edication. The orders read to care physician in the AM for the could be may administer Ativan 0.5 mouth. The orders read to care physician in the electronic sted 12/01/24 at 7:43 AM 3 entered an order for Ativan 3. Give 0.5 mg by mouth one to COPD with acute the medication order triggered an identified drug allergy.	F	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	<u></u>	(X3) DATE SURVEY COMPLETED
		345405	B. WING _			C 12/23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY 1735 TODDVILLE ROA CHARLOTTE, NC 28	AD	12/25/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 684	Ativan oral tablet 0.5 related to COPD with medication was adm AM and signed off b. A nursing note writte 12/01/24 at 12:14 Pl. had received report. Resident #1 was resulted at throughout the night #2 the resident was assessment Resider (low levels of oxyger of 60% (normal lever of supplemental oxy Emergency Medical Resident #1 was nor resuscitate (DNR) or in administering life success. Resident #1 by EMS at 8:30 AM. On 12/16/24 at 12:3 was conducted with she returned to the fand Nurse #1 gave Resident #1 had becand they had tried to did not have access.	r 2024 revealed an order for 5 mg by mouth on time only h acute exacerbation. The ninistered on 12/01/24 at 7:44 y Nurse #1. en by Nurse #2 dated M as a late entry revealed she from Nurse #1 who stated stless all evening and of bed multiple times have entresponsive. Upon the #1 was noted to be hypoxic in with an oxygen saturation I greater than 92%) on 4 liters gen via nasal cannula. Services (EMS) was notified, ted to have a do no order in place. EMS took over saving measures without the accordance of 12/01/24 at 7:00 AM ther report and stated en anxious during the night to the automated medication	F	884		
	getting a report from Manager #1 arrived #3 and Unit Manage Ativan for Resident is finished getting repo medication pass. Ur	Nurse #2 recalled she was Nurse #1 when Unit at the nurse's station. Nurse #1 then went to pull the #1 while she (Nurse #2) ort and began to start her hit Manager #1 brought her a fivan in it for Resident #1 and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/23/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•	12/23/2024	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 684	#2 stated she did not the resident's allergic Ativan 0.5 mg along medication. When sh room, Resident #1 wher fall mat. Nurse #1 resident to get up to her medication. Nurse medication and state provided and Nurse: then alerted by NA#1 later that something Nurse #2 and Nurse room to find her lying open and fixed, mou EMS were called and Nurse #2 stated Resideceased by EMS at On 12/16/24 at 12:53 was conducted with on 11/30/24 through PM to 7:00 AM shift responsible for Resident because she getting in/ out of bed "overwhelmed" with went to the resident's she could do. Nurse screaming out, crawl anxious. At approxim Nurse #1 again came not know what to do then told her the faci Ativan, she stated sh the resident Ativan b	nister the medication. Nurse ask any questions or look at as prior to administering the with Resident #1's morning are went into the resident's as sitting up on the floor on 2 and NA #1 assisted the the side of the bed to take as #2 administered the difference the difference the difference the management of the side of the bed to take as #2 left the room. She was approximately 5-10 minutes was wrong with Resident #1. #1 went into the resident's pon the bed with her eyes the open and a faint pulse. If the vital signs were obtained, as #30 AM. By PM a telephone interview Nurse #3. Nurse #3 worked 12/1/2024 during the 7:00 with Nurse #1 but was not the tent #1. Nurse #3 stated what to do regarding the expression was a signal with the tent was and kept was very anxious and kept	F 6	984			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345405	B. WING			l	23/2024
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CHARLUI	TE HEALTH & REHABIL	HATION CENTER		(CHARLOTTE, NC 28214		
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IAG	NEGOEMONT ON		IAG		DEFICIENCY)		
F 684	Continued From page	e 43	F	684			
	oxygen tubing and cr	awling out of bed. The					
		urse #3 had access to the					
	automated medicatio	n dispensing system. but					
		two nurses waited until the					
		asked Unit Manager #1 to					
	be a second witness	to pull the Ativan out of the					
	automated medicatio	n dispensing system.					
	machine. Nurse #3 ar	nd Unit Manager #1 then					
	pulled Ativan 0.5 mg	from the automated					
	medication dispensin	g system for Resident #1					
		took the medication and					
		administer. The interview					
		no alerts that popped up in					
		ation dispensing system.					
		hen Nurse #3 put the Ativan					
		c charting system an allergy					
		she bypassed the alert in the					
	•	Nurse #3 did not know if they					
		medication or not and left					
	·	ing the medication order.					
	Nurse #3 recalled she						
		m the DON that Resident #1					
		medication, and Nurse #3					
		order into the Medication					
		d (MAR). Nurse #3 stated					
		not have bypassed the ystem but was not thinking					
		ation and just clicked the					
	•	e felt that Resident #1 had a					
		nd was "just excited" like					
		ne diagnosis and the Ativan					
		Nurse #3 stated she did not					
	•	allergy list. The interview					
		c on the situation, the nurses					
	should have contacte						
		Resident #1's change in					
	behavior.	,					
	On 12/16/24 at 10:19	AM an interview was					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345405	B. WING			1	23/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 121	23/2024
					735 TODDVILLE ROAD		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			CHARLOTTE, NC 28214		
(V4) ID	QUIMMADV ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 684	Continued From page		F	684			
		Manager #1. During the					
		she had come in on 12/01/24					
		all to orient Nurse #2 during					
		PM shift. The interview					
		at the facility around 7:12					
		dent #1 lying on her fall mat					
		ed Nurse #1 if she was					
		as on the fall mat and Nurse					
		safest place the resident					
	could be. The intervie	urse #2 when Nurse #3					
	_	cond witness to remove					
		e automated medication					
	dispensing system. for						
		ld Resident #1 had been					
		d and had been throwing					
		ring the night and Nurse #1					
		to the automated medication					
		pull the medication. Unit					
		d she went with Nurse #3					
	and removed the med	dication from the automated					
	medication dispensin	g system. as the second					
	witness. She took the	e medication and gave it to					
	**	ted her to administer the					
		nt #1. She was then notified					
	` `	e she could not recall) that					
		ing. Resident #1 was a					
		the room to find Nurse #1,					
	Nurse #2 and NA #1						
		ready been contacted and					
		acility. The interview further				ĺ	
	-	er #1 was new to the facility				ſ	
		with Resident #1. Unit				ĺ	
		Resident #1 had a change				ĺ	
	•	erienced difficulty breathing				ĺ	
	-	nould have notified the				ĺ	
	on-call Nurse Practiti	oner of the residents				ĺ	
	condition.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345405	B. WING				00/2004
NAME OF PE	ROVIDER OR SUPPLIER	0.0.00		9	STREET ADDRESS, CITY, STATE, ZIP CODE	121	23/2024
NAME OF T	TOVIDEN ON SOI I EIEN				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	e 45	F	684			
Γ 004	EMS records dated 1 notified at 8:13 AM, d 8:18 AM, arrived on s resident at 8:30 AM v cardiac/ respiratory a Resident #1 was four was apneic (without to Resident #1 had no had not resuscitate order pronounced decease On 12/16/24 at 2:24 F was conducted with to Nursing (DON). The I #1 called her on 12/0 #1 had expired. The I new to the facility and provider that Resident change of condition, a completed an assess interview revealed she back into the system for the night of 11/30/because the nurse had the resident's change stated all nurses involted the facility protocol if a change of condition. The DON revealed lo documentation she sidocumented allergy to was administered at a DON stated it was are when she was notified administered a medic documented allergy to suspended the nurse	2/01/24 revealed they were ispatched to the facility at ocene at 8:29 AM and to the with a chief complaint of the rest. Upon EMS arrival and lying in bed. The resident preathing) and pulseless. It is a valid do (DNR). She was doubt at 8:30 AM. PM a telephone interview the former Director of DON stated Unit Manager 1/24 to notify her Resident DON indicated nurses were did not notify the on-call at #1 had experienced a land the nurses should have ment on the resident. The lee instructed Nurse #1 to go and document nursing notes 24 through 12/01/24 and not originally documented a for condition. The DON lived should have followed a resident had experienced and notified the physician. Tooking through law Resident #1 had a lot the medication Ativan she of the medication that a lot of Resident #1 being lation she had a lot and she immediately is involved. She notified the		084			
	Medical Director on 1 Resident #1 had rece	2/01/24 at 1:00 PM vived the medication Ativan					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 2/23/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/23/2024	
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	revealed the facility I Ativan if a resident w was to administer 0.3 dose. The nurses we nurse who administer #2) was still in orient questions prior to giv she was told to do so was her preceptor. T involved should have for administration of review of the resider Nurse #3 should have	allergy. The interview had standing orders to use was having agitation which 5mg of Ativan as a one-time ere new to the facility and the ered the medication (Nurse ation and did not ask any wing it to the resident because to by Unit Manager #1, who the DON stated all nurses ere followed the facility protocol medication which included int's allergies. She stated we never bypassed the allergy stem. All nurses were	F 6	84			
	conducted with the A Nurse Consultant. TI 12/01/24 around 7:3 Ativan 0.5 mg to Res restlessness and agi physician orders the Regional Nurse Con administered Ativan and Resident #1 was with a low oxygen sa called to the facility, pronounced as dece Former Director of N the documentation, a suspended the nurse investigation into the responsible for the re 7:00 AM shift on 11/3 needed guidance from	AM an interview was administrator and Regional he interview revealed on 0 AM, Nurse #2 administered sident #1 due to behaviors of station based off of standing facility had in place. The sultant stated Nurse #2 to Resident #1 at 7:44 AM is then found unresponsive atturation level. EMS was and the resident was ased. At 11:30 AM the tursing (DON) was reviewing and they immediately es involved and completed an incident. Nurse #1 was esident during the 7:00 PM to 30/24 through 12/01/24 and im Nurse #3 who told her reder for Ativan 0.5mg. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345405	B. WING_			C 2/23/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/20/2024	
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	involved in the incided documented assessive experienced difficulty increased anxiety and Resident #1 had expected anxiety and the to have a documented Ativan administered nurses involved in the #1 had no allergies to bypassed the alerts record when entering the resident's MAR. nurses were responsive resident did not have and they did not. The stated nurses should resident assessment the shift especially if resident's condition. On 12/16/24 at 1:34 was conducted with Practitioner. During the was not contacted or regarding Resident #4 unusual because the know if anything acuments was having trouble to immediately sent the an evaluation. On 12/16/24 at 1:38 was conducted with The MD stated the Data of the manual stat	ent notified a provider or ments when Resident #1 had a breathing, restlessness or d should have identified erienced a change of hight. Resident #1 was noted at allergy to the medication at 7:44 AM. None of the four e incident verified Resident to the medication. Nurse #3 in the electronic medical githe medication order into The Administrator stated the sible for verifying that the e an allergy to the medication, at Regional Nurse Consultant to be documenting the sand vital signs throughout there were changes to the hinterview she stated she in 11/30/24 or 12/01/24 the hinterview she stated that it was a facility typically would let her the happened but if a resident treathing, she would have a resident to the hospital for PM a telephone interview the Medical Director (MD). FON notified him of an eed on 12/01/24 when a nurse	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
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		345405	B. WING			l	23/2024
	ROVIDER OR SUPPLIER	BILITATION CENTER	•	173	REET ADDRESS, CITY, STATE, ZIP CODE 35 TODDVILLE ROAD HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	interview revealed was on 12/01/24 at medication error had Resident #1 had excondition starting at 11/30/24. The MD Practitioner would happened after 5:05 facility should have hospital for an evaluation the nursing progrese pisode and could dioxide (A waste pure metabolism. It is trabloodstream to the gas.) in the blood. increased CO2 lev behavior such as galong with confusic contacted the Nurse sent the resident to because the resident to because the resident to the past and needed (non-invasive vention.) The Administrator of jeopardy on 12/17/2. The facility provide action plan with a confusion of the past and needed (non-invasive vention) and with a confusion plan with a	the first time he was contacted to 1:00 PM and told a and occurred. He wasn't notified experienced a change of at approximately 3:00 PM on stated the on-call Nurse have been notified if it to PM. The MD stated the experienced are from review of experienced are from review of experienced and increased carbon roduct produced during ansported through the lungs, where it is exhaled as a He stated the result of els would be psychotic getting up and down out of bed on. The MD stated if they had be Practitioner, she would have to the hospital for an evaluation ent was likely having an acute DPD as she had experienced in end to be on a BiPap ellation therapy). Was notified of the immediate 24 at 6:30 PM.	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	DDE	12/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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 684	change in condition attention, failed to oboxygen saturations on 11/30/24 through	to identify a significant that required medical otain vital signs and ongoing during the evening and night 12/01/24. On 11/30/24 during	F	684			
	showed signs of rest onto the floor and ve she was experiencin continued from 11:00 Resident was noted with a blood pressur respiratory rate of 4 of 54%. Resident #1 by Emergency Medic	DPM shift, Resident #1 tlessness, agitation, crawling brbally expressed to staff that g difficulty breathing which DPM to 7:00 AM. At 8:13 AM in her room unresponsive e of 94/60, pulse rate of 111, and oxygen saturation level was pronounced deceased cal Services (EMS) staff at					
	showed signs of rest according to the licer Licensed nurses mare resident #1 comfortate assist Resident #1 therefrom bed to chain become more comform Resident #1's oxyge approximately 2:00 from one supervision properly assess the Address how the fact residents having the the same deficient property as a confident of the same deficient property as a confident prope	ility will identify other potential to be affected by ractice; e at risk of this occurring. audit was completed by the					
	Director of Nursing a	and designee to review our reports, and vital sign logs					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345405	B. WING				23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214			23/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page		F	684				
	noted changes in res and the physician no forward. The audit als ensure that residents noted in the electroni completed by the Dir designees on 12/03/2	ector of nursing and						
	deficient practice will Education started by 12/1/2024 for the chaincluded providing co	not recur; the Director of Nursing on						
	signs, signs of restles saturations, and any also included the doc comprehensive asse medical record. All ed the Director of Nursin 12/06/2024. All licens	esness, agitation, oxygen breathing issues. Education cumentation of essent into the electronic ducation was completed by and/or designee as of sed nurses and medication has education will not be able						
	licensed nurses and education during the Director of Nursing u Coordinator is hired. made the Director of responsibility on 12/2 Staff Development C is filled. Director of N nurses and medication to working their next 12/6/2024. Director of certified nursing assistant and provided the second statement of the second	medication aides will receive orientation process by the ntil a Staff Development The facility Administrator Nursing aware of this 1/2024 and will educated the coordinator once that position ursing ensured all licensed on aides were educated prior						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345405	B. WING			C 12/23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	CODE	1220.202
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	The state of the s	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	conditions included breathing and change to be taken as per p changes, weekly and residents. All nursing notes and reviewed by the nursing clinical median condition to ensur saturations were don't his occurs 5 times 12/06/2024. Director review nursing notes any change in condition to reviews will be Nursing or Designed weeks.	ge 51 2024. Example of change in but not limited to, difficulty ge in mental status. Vitals are olicy to include with acute devery shift for skilled d 24-hour reports will be sing clinical team during stings for any noted changes e vital signs and oxygen he for changes in condition. Weekly and is ongoing as of of Nursing or designee will so over the weekend to ensure tion is addressed. Nursing completed by the Director of e on 5 residents weekly x 12	F	684		
	designee will intervied 12 weeks to ensure change in condition. Indicate how the fact performance to make sustained; As of 12/3/2024 the be reviewed by the A Nursing in the weeks the monthly Quality Improvement (QAPI Interdisciplinary Tea 3 months. Changes necessary to maintal safety. The IDT teams	ew 5 nurse aides weekly for they are reporting any to their charge nurse verbally. Ility plans to monitor its e sure that solutions are results of the monitoring will Administrator or Director of y Risk meeting and during Assurance Performance) meeting with the m (IDT) as of 12/03/2024 for will be made to the plan as in compliance with resident				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C 12/23/2024	
	ROVIDER OR SUPPLIER TE HEALTH & REHABIL	ITATION CENTER	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page Director, Social Work Minimum Data Set (M	er, Activities Director and	F	684			
F 726 SS=J	validated by onsite verstaff interviews. The nursing staff had rece condition and include assessments that requipal obtaining vital signs, agitation, oxygen satissues. Education also documentation of continuous the electronic mewere interviewed reganursing staff if they see of condition. The facil monitoring results and reviewed. The IJ remompletion date for the 12/07/24 was validated Competent Nursing SCFR(s): 483.35(a)(3)(a)(b) §483.35 Nursing Sent The facility must have the appropriate competent safety and at practicable physical, and considering the mediagnoses of the facility must have the safety and at practicable physical, and considering the mediagnoses of the facility must facility must have the safety and at practicable physical, and considering the mediagnoses of the facility must facility must have the appropriate competent safety and at practicable physical, and considering the mediagnoses of the facility must have the appropriate competent safety and at practicable physical, and considering the mediagnoses of the facility must have the appropriate competent safety and at practicable physical, and considering the mediagnoses of the facility must have the appropriate competent safety and at practicable physical, and considering the mediagnoses of the facility must have the appropriate competent safety and at practicable physical the facility must have the appropriate competent safety and at practicable physical the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and the facility must have the appropriate competent safety and	rective action plan was erification through facility interviews revealed all sived education on change in d providing comprehensive quire medical attention, signs of restlessness, urations, and any breathing o included the apprehensive assessment edical record. Nurse Aides arding notification to the ee a resident with a change ity's in-service log, d training material was avoid date of 12/07/24 and the corrective action plan of ed. Staff (4)(c) vices e sufficient nursing staff with etencies and skills sets to elated services to assure that or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care	F	726			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		LETED
		345405	B. WING _				23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD HARLOTTE, NC 28214	1 121	20/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	licensed nurses have and skill sets necess needs, as identified to assessments, and do §483.35(a)(4) Provide limited to assessing, implementing resident to resident's needs. §483.35(c) Proficient The facility must ensite to demonstrate complete thiques necessar needs, as identified to assessments, and do This REQUIREMEN' by: Based on record revistaff, Medical Direct failed to provide effect for new hires includir validations and specified to precept Nurse and electronic medical received a complete to precept Nurse #2 and Resident #1 who have Ativan. At 8:13 AM Froom unresponsive as pressure 94/60 (norm 120/80), pulse 111(norespiratory rate 4 (normal pressure part of the sident was not pressure 4 (normal pressure part of the sident was not pressure 4 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not pressure 94/60 (normal pressure part of the sident was not	cility must ensure that e the specific competencies ary to care for residents' through resident escribed in the plan of care. ing care includes but is not evaluating, planning and nt care plans and responding cy of nurse aides. ure that nurse aides are able betency in skills and ry to care for residents' through resident escribed in the plan of care. T is not met as evidenced riew, and interviews with or and Pharmacist, the facility ctive training and orientation and preceptorship, skills iffic training related to and resident allergies in the cord (EMR) system alerts. ager #1, who had not orientation, was scheduled Under Unit Manager #1's	F	726	Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345405	B. WING				23/2024
	ROVIDER OR SUPPLIER			STRE	TODDVILLE ROAD RLOTTE, NC 28214	1 121	23/2024
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F 726	was pronounced de Medical Services (E incomplete orientation Manager #1 put all radverse outcome. For example b. the from complete orientation before she worked i "D" (no actual harm minimal harm that is The deficient practic reviewed for compete The findings included This tag is cross-reformedication) as a on an allergy to Ativan List in the electronic 08/20/24. The medication was then pulled from medication manage was orienting under Manager, administe 12/01/24 at 7:44 AM	ter than 92%). Resident #1 ceased by Emergency MS) staff at 8:30 AM. The on and training for Unit esidents at risk for a serious facility failed to provide and training for Nurse #1 independently. This is cited at with potential for more than immediate jeopardy). The occurred for 2 of 4 nurses tencies. d: erred to: ord review, and interviews irrector and Pharmacist, the ent a significant medication t #1 received a dose of Ativan	F	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•	12/20/2024	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 726	Continued From page	ge 55	F 7	726			
	Services (EMS) stat	ed by Emergency Medical ff at 8:30 AM. This deficient r 1 of 3 sampled residents					
	revealed she had be undated, incomplete "Unit Manager" reve received training on supervising Nurse A pharmacy services, clinical skills compe completed nursing of	anager #1's employee file een hired on 10/15/24. An e skills validation record titled, ealed Unit Manager #1 had not facility equipment, sides (NA), clinical processes, EMR documentation, or tencies. She also had not competencies under the ager Responsibilities".					
	conducted with Unit stated she was hired three days of class of Scheduler. The train to the company, dis discussing the facilitiand paid time off. Owith the Staff Developing over infection enhanced barrier prinformative videos. Is skills validation pacification paced with a precessist her in complet competencies. Unit else happened after with a preceptor or after the in-class trait the Former Director education or training	9 AM an interview was Manager #1. Unit Manger #1 d on 10/15/24 and received orientation with the facility ning included introducing her cussing the schedule, ty policy regarding attendance on the second day she met opment Coordinator (SDC) control, contact isolation, ecautions and watching Unit Manager #1 was given a ket and told she would be potor and the preceptor would diting the nursing Manager #1 stated nothing that, she was never placed received any more training ining. She stated she asked of Nursing about receiving g and she would say okay, but the poton of the processor of the processo					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING				C	
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 12	/23/2024	
					TODDVILLE ROAD			
CHARLOT	TE HEALTH & REH	ABILITATION CENTER		CHA	ARLOTTE, NC 28214			
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F 726	Continued From	page 56) F	726				
		and Nurse #2 were hired the						
		ve a SDC and their orientation						
		of what she had received. Nurse						
		her that she hadn't received any						
		ng. Unit Manager #1 stated on						
		s scheduled to precept Nurse #2.						
		d not even received orientation						
	herself but was to	old by the Scheduler that Nurse						
	#2 just needed su	ipport because she really did not						
		Unit Manager#1 stated she had						
		on sheet however it wasn't						
		than the three days of classroom						
		Manager #1 stated no one from						
		one over verifying residents						
		administration of medication or						
	•	ated to resident allergies. She						
		she should have verified the						
		s but thought Nurse #1 had She was not the primary nurse						
		ing as a witness. The interview						
		rom the facility had gone over						
		or change of condition with her						
	until after the inci	-						
		D:56 AM an interview was						
		e Scheduler. The interview						
		isted during the orientation						
		ided each newly hired Nurse						
		h a skills check off sheet. She						
	I -	hired staff received an						
		three days and then were						
		ceptor on the units that would						
		hired staff member was area on the checklist. The						
		d once the checklist was						
		d once the checklist was						
		nt Coordinator who placed it into						
		e. The Scheduler stated the						
		od of time with no SDC in the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345405	B. WING			1	C 23/2024
NAME OF PE	ROVIDER OR SUPPLIER	0.0.00		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 121	23/2024
TO THE OT THE	TO VIDER OR GOT FEILING				735 TODDVILLE ROAD		
CHARLOT	TE HEALTH & REHABIL	ITATION CENTER			CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 726	Continued From page	e 57	F	726			
Γ /20	building from Octobe Former Director of No for gathering the com- oversight of newly his stated she had not se checklist from Nurse She stated Nurse #2 Nurse #3 had a comp On 12/17/24 at 9:24 a conducted with the S Coordinator (SDC). S facility at the end of Ountil 12/16/24. The S was responsible for a that time. Orientation days in person class Nurse Aides (NA). A nurses were typically at least a week or two orientation. The interreceived access to the dispensing system do The SDC stated she and Unit Manager #1 validation record or re orientation because s the building for one of part of the orientation residents allergies pr medication. An interview conduct with the Former Direct revealed Unit Manag to notify her Resident looking through docu-	r 2024 until 12/16/24 and the ursing had been responsible upleted checklist and red staff. The Scheduler een a completed skills #1 and Unit Manager #1. was still in orientation and oleted skills checklist. AM an interview was taff Development She stated she had left the October and not returned DC stated the Former DON all nursing orientation during in the facility consists of 3-4 time for the Nurses and fter the class orientation placed with a preceptor for after the in-class view revealed Nurses are automated medication uring the class orientation. was unaware if Nurse #1, had completed their skills eccived a precepted she had only been back into ay. The SDC verified that a training included reviewing for to administration of sed on 12/16/24 at 2:24 PM ctor of Nursing (DON) er #1 called her on 12/01/24 at #1 had expired. After mentation she saw Resident	F	726			
	to notify her Residen looking through docu #1 had a documented	t #1 had expired. After					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345405	B. WING			C 2/23/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		2/23/2024		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 726	was notified, and shourses involved. Shourses involved. Shours at 1:00 PM. The interview shaving agitation 0.5mg of Ativan as a were new to the facility and administered the me in orientation and did to giving it to the residence of the pool of t	round 11:00 AM when she e immediately suspended the e notified the Medical Director erview revealed the facility to use Ativan if a resident which was to administer none-time dose. The nurses lity and the nurse who dication (Nurse #2) was still d not ask any questions prior ident because she was told to per #1 who was her preceptor. nurses involved should have protocol for administration of	F 7	26				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONST		(X3) DATE SURVEY COMPLETED	
		345405	B. WING			4	C
	ROVIDER OR SUPPLIER	BILITATION CENTER		1735 TO	ADDRESS, CITY, STATE, ZIP CODE DDVILLE ROAD OTTE, NC 28214		2/23/2024
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 726	The Administrator jeopardy on 01/07. b. Review of Nurse she had been hire incomplete skills v Nurse" revealed N on Pharmacy Serv Record (EMR) clin or clinical skills cond with Nurse #1 revealed in the condition of the conditio	was notified of the immediate /25 at 4:15 PM. e #1's employee file revealed don 11/12/24. An undated, alidation record titled, "Charge urse #1 did not receive training rices, Electronic Medical ical documentation for allergies mpetencies. ucted on 12/17/24 at 3:56 PM ealed she was hired by the and received an in-person days. She stated following the was assigned with a nurse that PRN) in the facility and was duration of two days before er own because the staff pricing in the facility. Nurse #1 me from a hospital setting received 8 weeks' training, and received an orientation and no one from the eart training on resident allergies erts. ted the following corrective	F	726			
	While interviewing	g 4 nurses involved in the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL	DING	(X3) DATE SURVEY COMPLETED	
345405 B. WIN	3	C	
NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	12/23/2024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES I PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TA	FIX (EACH CORRECTIVE ACTION SHOULD B		
F 726 Continued From page 60 incident occurring on 12/1/2024, It was mentioned that they did not feel as if they received proper orientation from the facility. The facilities failure to have a proper orientation and training program in place, led to an undesirable resident outcome. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 12/4/2024 the Administrator identified that current clinical staff hired on or after 10/15/2024 were not properly orientated, onboarded, and thoroughly trained to completely fulfill their role. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; As of 12/4/24 it was decided by the Administrator to have identified employees return for a corrected orientation, onboarding, and training process beginning on 12/09/2024. Licensed Nurses completed Medication Pass Observations with the Director of Nursing starting on 12/3/2024 after medication error on 12/1/2024. Nurses who did not complete this Medication Pass Observation before their next scheduled shift, were not allowed to work until it was completed. Skills Validations were started on 12/3/2024 for Licensed Nurses by the Director of Nursing or designee after incident on 12/1/2024. All Licensed Nurses hired on 10/15/2024 or after participated in the training program on 12/9/2024. Those who did not attend were not allowed to return until they went through the training program. Nurses involved in the incident were suspended on 12/1/2024 pending investigation.	726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	LITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		DE	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	Nurse # 2 turned in a 12/7/2024. The Unit terminated and appears was brought back or the training program immediately on 12/2 held by the Administ Human Resources I prior to accepting rewithout preceptor survithout preceptor of the Sk Medication Pass Observation, awas completed by disupervisor. The Director of Clinical Straining on company appropriate orientatic	d of Nursing as of 12/4/2024. a resignation letter on	F	726			
	Administrator, Direct Resources Director. Coordinator is hired, administrator on the process.	or of Nursing, and Human Once a Staff Development they will be educated by the expected orientation					
	designee, and Huma ensure that compan orientation, onboard newly hired clinician	an Resources Director will y expectations for appropriate ing, and thorough training for s are implemented beginning ctor of Nursing will complete					
	Company expectation	ons are as follows: 5 days of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			1	23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		1735 TODD\	DRESS, CITY, STATE, ZIP CODE VILLE ROAD TE, NC 28214	1 12/1	20/2027
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B PROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	no less than 2 week onboarding and trair clinical preceptor. Prior to accepting re without preceptor su Nursing or designee completion of the Sk Medication Pass Ob Observation. Skills \ Pass Observation, a will be completed by supervisor. Effective Administrator will be ensuring implementa plan. Indicate how the fact performance to mak sustained; As of 12/9/2024, HR employees weekly x are receiving proper comfortable with the provided. As of 12/3/2024 Med will be completed by Designee on 5 licens weeks to ensure resemedications with list Allergies are listed owhen the EMAR is pelectronic health received.	in adhering to the ientation agenda, followed by so of on-the-floor 1:1 aing with a center-designated sponsibility for an assignment pervision, the Director of must validate successful ills Validation Record, servation, and Treatment Validation Record, Medication and Treatment Observation designated preceptor or 12/04/2024, the ultimately responsible for ation of this corrective action illity plans to monitor its e sure that solutions are will interview new hire 12 weeks to ensure that they orientation and feel training that is being dication pass observations the Director of Nursing or seed nurses weekly x 12 idents do not receive ed allergies on the EMAR. In the EMAR and show upulled up or displayed in the	F	726			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING _		C 12/23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	1 12/20/2024
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 726	monthly QAPI meetir Team. Changes will I	e 63 Administrator during the ng with the Interdisciplinary be made to the plan as n compliance with resident	F 7	26	
F 760 SS=J	Safety. IJ removal date: 12/1 On 12/17/24, the corvalidated by onsite vistaff interviews. The facility staff were proexpectations of the forientation adhering orientation agenda, for weeks of on-the-floor with a center-designate of accepting responsive without preceptor superinservice log, monitor material was reviewed 12/10/24 and the cortex of the corrective action.	rective action plan was erification through facility interviews revealed the vided with company ollowing: 5 days of classroom to the company-specific ollowed by no less than 2 r 1:1 onboarding and training ated clinical preceptor. Prior ibility for an assignment pervision. The facility's oring results and training ed. The IJ removal date of inpliance date of 12/10/24 for	F 7	60	
	medication errors. This REQUIREMENT by: Based on record revistaff, Medical Director failed to prevent a signification of the control of the c	ure that its- nts are free of any significant T is not met as evidenced riew, and interviews with or and Pharmacist, the facility gnificant medication error ceived a dose of Ativan (a d as a sedative medication) Resident #1 had an allergy to on the Allergy List in the		Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345405	B. WING		12	C 2/23/2024
NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	The medication orde electronic health record the electronic medicated ue to the allergy, but and entered the order then pulled from the medication managen was orienting under the Manager, administer 12/01/24 at 7:44 AM. Resident #1 became abnormal vital signs. pronounced decease Services (EMS) staff practice occurred for reviewed for medicate. The findings included An undated "After-Hooders" revealed for behavior the nurse milligram (mg) by most the action in 20 minurespond to the medicate notify the primary carfurther orders. Resident #1 was read 08/20/24 with diagno pulmonary disease (failure.	cord (EMR) on 08/20/24. If was entered into the ord by Nurse #3. She stated all record flagged the order it she "bypassed" the alert in the EMR, which was automated system for ment. Nurse #2, a nurse who the supervision of the United the medication on On 12/01/24 at 8:13 AM unresponsive with seriously Resident #1 was ad by Emergency Medical at 8:30 AM. This deficient 1 of 3 sampled residents ion errors. It: Durs Standing Physician aggression or agitated any administer Ativan 0.5 buth. The nurse could repeat the if the resident did not the interest of the physician in the AM for dependent of the physician in the AM for experience of the could response of chronic obstructive COPD) and respiratory electronic medical record included the medication was	F 76			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345405	B. WING_			C 2/23/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC 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 760	Continued From pag	ge 65	F 7	60			
		t #1's quarterly Minimum Data ed 11/29/24 revealed she was					
	dated 12/01/24 at 11 Nursing (DON) revea ordered and adminis one-time dose with a medication by Nurse was documented as	ty's medication error report :20 AM by the Director of aled Resident #1 was stered Ativan 0.5 mg for a a documented allergy to the e #2. The result of the incident Resident #1 experienced an The medication error was cal Director.					
	medical record dated revealed Nurse #3 e oral tablet 0.5 mg. G time only related to 0 Pulmonary Disease 12/01/24 at 9:00 AM	stration note in the electronic d 12/01/24 at 7:43 AM entered an order for Ativan sive 0.5 mg by mouth one Chronic Obstructive with Acute Exacerbation until . The medication order a system identified drug					
	(MAR) for December Ativan oral tablet 0.5 related to COPD with	ation Administration Record r 2024 revealed an order for 5 mg by mouth on time only h acute exacerbation. The hinistered on 12/01/24 at 7:44 y Nurse #1.					
	conducted with Nurs employed by the fac stated she wanted to	PM an interview was see #1, who was no longer ility. During the interview she to use her initial statement to conse to questions asked.					
		and signed by Nurse #1 on y the facility revealed she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			، ا	c	
		345405	B. WING				23/2024	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 121	23/2024	
	1011211 011 001 1 21211				735 TODDVILLE ROAD			
CHARLOT	TE HEALTH & REHA	BILITATION CENTER			CHARLOTTE, NC 28214			
				`	1			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR 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 760	Continued From pa	age 66	F	760				
	assigned Resident	#1 during the 7:00 PM to 7:00						
		24 - 12/1/2024. The statement						
	revealed Resident	#1 kept getting out of the bed						
	and laying on the fl	loor during the shift. Nurse #3						
	asked her if the res	sident had any Ativan available						
		ed she wasn't sure. Nurse #3						
		cility had standing orders for						
		be pulled from the automated						
		tion management. Nurse #1						
		ess the automated system for						
	•	ement and had to wait until the eto obtain the Ativan. When						
		ed at 7:00 AM Nurse #1 gave a						
		NA #1 came to the office after						
		tion pass and stated						
		ong with Resident #1. Nurse #3						
		go to the resident's room for						
		#1 did. Upon arrival to the						
		sident #1 was face up, lying in						
	bed with a slow res	sponse to communicate. She						
	asked for vital sign	s and for someone to call EMS						
	after feeling a weal	k pulse on the resident. Nurse						
		a sternal rub on the resident						
		After EMS arrived, she was						
		ad expired. Nurse #1 was later						
		ad received by mouth Ativan						
		n allergy to the medication.						
		her statement she did not						
		lication but had signed off on						
		resident and had initiated the						
	•	nt #1's need for the medication.						
		53 PM an interview was						
		rse #3. Nurse #3 worked on						
		24. during the 7:00 PM to 7:00						
		e #1 but was not responsible						
		urse #3 stated Nurse #1 asked						
	ner what to do rega	arding the resident because						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040400		STREET ADDRESS, CITY, STATE, ZIP C		2/23/2024	
TO WILL OF TH	NOVIDEN ON OUT FIELD			1735 TODDVILLE ROAD	052		
CHARLOT	TE HEALTH & REHA	ABILITATION CENTER		CHARLOTTE, NC 28214			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From p	page 67	F7	760			
	she was very anx bed. Nurse #1 set situation so Nurse with her to see wh stated Resident # out of the bed and 3:00 AM on 12/1/2 her and stated sh Resident #1. Nurshad standing order told her it was okabecause the reside screaming, pulling crawling out of be #3 had access to medication manager to medication manager for Resident #1 and Unit Manager for Resident #	ious and kept getting in/ out of emed "overwhelmed" with the e #3 went to the resident's room nat she could do. Nurse #3 1 was screaming out, crawling divery anxious. At approximately 2024, Nurse #1 again came to be did not know what to do with se #3 then told her the facility ers for Ativan, she stated she hay to give the resident Ativan lent was "all over the place" by gon her oxygen tubing and did. The interview revealed Nurse the automated system for gement, but Nurse #1 did not. The interview revealed Nurse the automated system for gement, but Nurse #1 did not. The interview is a second to a third the day shift arrived anager #1 to be a second to a third the day shift arrived anager #1 to be a second to a third the day shift arrived anager #1 to be a second to a third the automated are to Nurse #3 in #1 then pulled Ativan 0.5 mg and Unit Manager #1 took the lave it to Nurse #2 to administer. I we all there were no alerts that automated system for gement. However, when Nurse order in the electronic charting alert did pop up and she to in the system. At that time know if they had administered not and left the facility after cation order. She then received the facility from the DON that					
	Nurse #3 had put Medication Admin #3 stated she kne bypassed the alle	an allergy to the medication, and the standing order into the histration Record (MAR). Nurse we she should not have rgy alerts in the system but was y about the situation and just					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345405	B. WING _				C 23/2024
	ROVIDER OR SUPPLIER	ILITATION CENTER	1	1735 T	T ADDRESS, CITY, STATE, ZIP CODE ODDVILLE ROAD RLOTTE, NC 28214		20/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	clicked the button. S Resident #1 had a c "just excited" like me diagnosis and the A Nurse #3 stated she allergy list. On 12/16/24 at 10:1 conducted with Unit interview she stated as the manager on the 7:00 AM to 7:00 revealed she arrived AM and was touchir Nurse #3 asked her remove Ativan 0.5m for medication mana to agitation. She wa very restless, agitate herself out of bed de did not have access medication manage Unit Manager #1 we removed the medica witness. After, she t it to Nurse #2 whom instructed her to adi Resident #1. On 12/16/24 at 12:0 conducted with Nurs interview she stated 6:30 AM on 12/01/2 her fall mat on the fl who told her not to g because she had be bed to the floor all n with the resident who	ge 68 She stated she felt that diagnosis of COPD and was post residents with the tivan would help calm her. It did not review the resident's and an	F	760			

· ,		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345405	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12/23/2024	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	like she did not want she had her back to oxygen tubing. Nurse #1 continued to unta tubing cord. NA #1 th out her name. When #1 was lying flat on hup at the ceiling and would not respond to Nurse #2 who was ir resident's room. NA until Nurse #1 and N Nurse #1 was doing to try and get her to not. EMS was called care once they arrived to 12/16/24 at 12:30 conducted with Nurse she stated she worke shift on 12/01/24. The she came in at 7:00 report and stated Reduring the night and resident Ativan but dautomated system for Nurse #2 was getting when Unit Manager station. Nurse #3 and to pull the Ativan for finished getting report and stated to her to a Nurse #2 stated she look at the resident's administering the Ativan the Ativan stated to her to a Nurse #2 stated she look at the resident's administering the Ativan to 2000 the control of the stated she look at the resident's administering the Ativan to 2000 the control of the stated she look at the resident's administering the Ativan to 2000 the control of the contro	#1 said Resident #1 acted to take the medication, but the resident untangling #2 then left the room as NA ingle the resident's oxygen men heard the resident call she turned around Resident mer back with her eyes fixed mouth open. Resident #1 of her, so she yelled out for in the hallway outside of the #1 stayed with the resident turse #2 entered the room. In a sternal rub on the resident respond, however she did and took over the resident's ed. In PM an interview was the effect #1 was giving her sident #1 had been anxious they had tried to give the find not have access to the find management. The medication management was the proof of	F 7				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	CODE	12/20/2021	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	resident's room, sher fall mat. Nurse resident to get up ther medication. Numedication and staprovided and Nurs then alerted by NAminutes later that she resident #1. Nurse the resident's room with her eyes oper faint pulse. EMS wobtained. Nurse #2 pronounced decear A nursing note writ 12/02/24 at 8:10 A was made aware by was in possible dis NA #1 after the moentering the room, respond. Nurse #1 obtained and to capressure was 94/6 reading 120/80), p60-100), respirator rate 12-20) and ox (normal oxygen sa 92%), she was not undocumented am via nasal cannula. resident's name wi #1's oxygen saturatime with a reading scene and were abcare.	when she went into the se was sitting up on the floor on #2 and NA #1 assisted the to the side of the bed to take size #2 administered the sited the resident drank water se #2 left the room. She was #1 approximately five to ten something was wrong with se #2 and Nurse #1 went into to find her lying on the bed and fixed, mouth open and a sere called and vital signs were stated Resident #1 was sed by EMS at 8:30 AM. Iten by Nurse #1 dated M as a late entry revealed she by Nurse #2 that Resident #1 tress after being discovered by string medication pass. Upon the resident was slow to requested vital signs to be II EMS. Resident #1's blood O (normal blood pressure sulse 111 (normal pulse range by rate 4 (normal respiratory by year saturation level 54% turation level greater than sed to be receiving an ount of supplemental oxygen Nurse #1 continued to call the thout a response. Resident tion was checked for a second of 30%. EMS then arrived on sole to take over the resident's	F7	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345405	B. WING _			C 12/23/2024	
	ROVIDER OR SUPPLIER	ITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE ROAD CHARLOTTE, NC 28214			1 1220/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA		
F 760	notified at 8:13 AM, of 8:18 AM, arrived on serident at 8:30 AM was cardiac/ respiratory and Resident #1 was four was apneic (without the Resident #1 had not not resuscitate order pronounced decease on the EMS report for Ativan. On 12/16/24 at 2:24 the conducted with the for (DON). The DON stated with the for (DON). The DON stated when she was notified saw Resident #1 had medication Ativan she AM. The DON stated when she was notified suspended the nurse Medical Director at 1 revealed the facility had to administer 0.5 dose. The nurses we nurse who administer 0.5 dose. The nurses we nurse who administer was to administer 0.5 dose. The nurses we nurse who administer to 1.5 dose to 2.5 was her preceptor. The nurse was told to do so was her preceptor. The nurse was told	dispatched to the facility at scene at 8:29 AM and to the with a chief complaint of rrest. Upon EMS arrival and lying in bed. The resident breathing) and pulseless. Heart tones with a valid do (DNR). She was do at 8:30 AM. Allergies listed at Resident #1 included PM an interview was browner Director of Nursing ted Unit Manager #1 called butify her Resident #1 had at through documentation she as documented allergy to the end was administered at 7:44 at was around 11:00 AM dot, and she immediately is involved. She notified the 1:00 PM. The interview and standing orders to use as having agitation which simp of Ativan as a one-time are new to the facility and the red the medication (Nurse ation and did not ask any ling it to the resident because to by Unit Manager #1 who he DON stated all nurses followed the facility protocol medication which included it's allergies. She stated is never bypassed the allergy	F	760			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILD	NG		Ι,	C
		345405	B. WING				23/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CUADLO	TTE LIEALTIL O DELLA	DILITATION CENTED		17	735 TODDVILLE ROAD		
CHARLO	TTE HEALTH & REHA	BILITATION CENTER		С	HARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Nurse Consultant. 12/01/24 around 7 Ativan 0.5 mg to R restlessness and a and Unit Manager the automated sys management base facility had. The far give Ativan 0.5 mg #2 administered At and Resident #1 w with a low oxygen called to the facility pronounced as dec Former Director of the documentation allergy to the medi Regional Nurse Consultational Nurse #1 was respected an inversummediately suspected an inverse #1 was respected an inverse #1 was respected an inverse #1 was respected and inverse #1 was respected and inverse #1 was respected and inverse #1 was respected in the proposition of the pr	Administrator and Regional The interview revealed on :30 AM Nurse #2 administered esident #1 due to behaviors of gitation. At 7:30 AM Nurse #3 #1 pulled Ativan 0.5 mg out of	F	760			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214	•	212312024
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 760		e 73 The Administrator stated the ible for verifying that the	F 7	760		
		an allergy to the medication				
		PM an interview was ledical Director (MD). The notified him of an incident				
	that happened on 12 administered Ativan t documented allergy t					
	orders for the medica	the facility had standing ation for agitation as needed. id not check the resident's				
	allergies and just gav interview revealed he	ve the medication. The ewas contacted around 1:00				
	occurred earlier in the	d the medication error e morning. The MD stated had expired but it did not				
	the medication, howe	n anaphylactic reaction to ever, would not know unless ormed, and to his knowledge				
	it had not been done to have any rash or h	Resident #1 was not noted lives by the nursing staff.				
		was no justification for the ninister Ativan to the resident llergy.				
	On 12/16/24 at 2:18	PM an interview was harmacist. During the				
	interview he stated a would result in anaph	true medication allergy nylaxis (severe,				
	within minutes of exp	ic reaction that can occur osure to an allergen) and a Resident #1's medication				
	orders for Ativan 0.5r	e were no active physician ng from the pharmacy for id see an allergy listed for				
		revealed if the facility				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345405	B. WING		1	C 2/23/2024
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 760	would not have complete the system for medicate the facility. The state to the resident's all the medication. He report that showed Ativan 0.5mg was under Resident #1 stated the allergy of the nurses were presented in the property of the nurses were presented in the nurses were prese	g order for the medication, it me from the pharmacy, but ulled it from the automated tion management located at aff would not have been alerted lergy in the sytem when pulling a stated he completed a system on 12/01/24 the medication removed from the machine 's name. The Pharmacist error would have shown when autting the order into the record and the nurses would off on the allergy alert to get the move and move forward in the riew revealed the nurse would be alert. The pharmacist stated areceive medication with a lay. That is why alerts were put recognize prior to the medication.	F	760		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTR		(X3) DATE COMP	SURVEY LETED
		345405	B. WING _				23/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE	1 121	23/2024
CHARLOT	TE LIEALTH & DELIADII	ITATION CENTED		1735 TODE	DVILLE ROAD		
CHARLOI	TE HEALTH & REHABIL	ITATION CENTER		CHARLO	TTE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	e 75	F7	760			'
F 760	electronic order entry allergy but she "bypa the order which was to automated system for Nurse #2 Administered 12/01/24 at 7:44 AM. was noted in her room pressure of 94/60, purate of 4 and oxygen Resident #1 was promoved by the system of 11/2 showed signs of restlement according to the licental end of the system of 11/2 showed signs of restlement according to the licental end of the system of 11/2 showed signs of restlement according to the licental end of the system of 11/2 showed signs of restlement according to the licental end of the system of the syst	flagged the order due to the ssed" the alert and entered then pulled from the redication management. The determinant of the medication on the state of the medication of the state of the st	F7	760			
	to Resident #1. Atival mouth to Resident #1 The medication order electronic health reco Nurse #3. The electro administration record	ord system at 7:43 am by					
		ned through interviews with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345405	B. WING _				23/2024
	ROVIDER OR SUPPLIER	ITATION CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 735 TODDVILLE ROAD CHARLOTTE, NC 28214	, .=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page the above-mentioned On 12/02/2024, after nurses were given ac system for medication Director of Nursing. At 8:13 am Resident unresponsive with Vit 94/60, Pulse 111, ResEMS was called for tr Do Not Resuscitate. I resident #1 was pronapproximately 8:30an Upon review of the ch Nursing on 12/01/202 Resident #1 had an a of the allergy was unl was notified that Reswas given with a doct 12/1/2024. Nurse #3 and Nurse is by the facility Administration of the same deficient process.	the occurrence, all licensed cess to the automated management by the # 1 was in her room and al Signs as follows: BP sp 4, Oxygen sat level 54. ansport. Resident #1 was EMS arrived on scene and ounced deceased at m. The property of the experimental property of the experimenta		760			
	An audit of current re current medication lis Director of Nursing ar	sident's allergy listing and t was completed by the nd designee to ensure that ordered or given with the was completed by the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED	
		345405	B. WING				C 23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		1735 TO	FADDRESS, CITY, STATE, ZIP CODE DDDVILLE ROAD LOTTE, NC 28214	,	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	systemic changes m deficient practice will on 12/01/2024, Dire at 11:13 am by Nurs allergy to Ativan. The an investigation. Education started 12 Nursing for all licensaides on alerts in the order entry in the Maconducted for pulling automated system for ensure there is order checked prior to with flagged notifications flagged as an alert welectronic health reconurse will notify the plicensed nurse not renot be able to work to New licensed nurses the orientation proceensured all licensed were educated prior scheduled shift as of Medication observation nurses and medication the Director of Nursi residents are not recallergies on their EM are listed on the EM EMAR is pulled up to health record.	ares will be put into place or ade to ensure that the I not recur; ctor of Nursing was notified e #1 that Resident #1 had an e Director of Nursing started c/02/2024 by the Director of ed nurses and medication e electronic health record AR. Education was also g medications from the or medication management to r in place and allergies are adrawing medication. All will be reviewed when when entering the order in the ord by the nurse, and the obhysician for direction. Any eceiving this education will until receive education during ess. Director of Nursing nurses and medication aides to working their next	F	760			

	OF DEFICIENCIES CORRECTION			' '	(X3) DATE SURVEY COMPLETED		
		345405	B. WING				23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		1735	ET ADDRESS, CITY, STATE, ZIP CODE TODDVILLE ROAD RLOTTE, NC 28214	,	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	licensed nurses were residents do not recallergies on the EM/12/6/2024. Allergies show up when the Edisplayed in the elected Education was provided to the elected to the electronic health progress notes for an oallergy alerts were the electronic health progress notes for an oallergy alerts were be completed weekly lindicate how the fact performance to make sustained; As of 12/3/2024 the be reviewed by the electronic health progress notes for an oallergy alerts were be completed weekly lindicate how the fact performance to make sustained; As of 12/3/2024 the be reviewed by the electronic health progress notes for an oallergy alerts were be completed weekly lindicate how the fact performance to make sustained; As of 12/3/2024 the be reviewed by the elected to	arising or Designee on 5 ekly x 12 weeks to ensure eive medications with listed AR. Audits begin as of are listed on the EMAR and EMAR is pulled up or etronic health record. Ided to all licensed nurses g a standing order, allergies ensure the resident does not for the medication by the on 12/06/2024. Eviewed during the morning the nursing clinical team to fications are ordered that elergy too. This will be eks x 12 weeks. Regional Clinical Nurse or medication allergy alerts in a record by reviewing the ellergy alerts weekly to ensure the bypassed. These audits will by x 12 weeks. Illity plans to monitor its e sure that solutions are results of the monitoring will Administrator or Director of by Risk meeting and during Assurance Performance	F	760			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345405	B. WING _			C 12/23/2024
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1735 TODDVILLE ROAD CHARLOTTE, NC 28214		12.12.01.2.02.4
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	Director of Nursing, Worker, Activities Di (MDS) nurse. This m IJ removal date: 12/0 On 12/23/24, the corvalidated by onsite v staff interviews and interviews revealed education on alerts i order entry in the Maconducted for pulling automated system for ensure there was an were checked prior to flagged notifications flagged as an alert welectronic health reconurse will notify the Education was provithat before activating must be reviewed to have a listed allergy facility's in-service low material were review. The immediate jeopated to the province of	tof the Administrator, Medical Director, Social rector and Minimum Data Set neeting lasted for 1 hour. 07/2024. Trective action plan was rerification through facility record review. The all nursing staff had received in the electronic health record AR. Education was also g medications from the or medication management to a order in place and allergies so withdrawing medication. All will be reviewed when when entering the order in the ord by the nurse, and the ord by the nurse, and the ord solution order, allergies g a standing order, allergies ensure the resident does not for the medication. The og, audits and training	F7	60		