STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mecklenburg Heath and Rehabilitation	**2415 Sandy Porter Road , Charlotte, North Carolina, 28273**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/18/25 through 08/21/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D406C-H1.	E0000		09/11/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/18/25 through 08/21/25. Event ID #1D406C-H1. The following intakes were investigated: 861895, 861896, 861897, 861898, 861899, 861900, 861903, 861904. 1 of the 22 complaint allegations resulted in deficiency.	F0000		09/11/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	1. The facility failed to accurately code Minimum Data Set (MDS) assessments in the area of Special Treatments, Procedures, and Programs regarding Chemotherapy for 1 of 19 sampled residents (Resident #9). Modification was completed on the identified assessment and submitted on 8/21/25. 2. Current facility residents are at risk of being affected by the deficient practice. On 8/20/25, the Regional Director of Clinical Reimbursement (RDCR) completed an audit of MDS assessments completed for the past 30 days to ensure Special Treatments, Procedures, and Programs were coded correctly. No new findings were identified. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Education was provided to the Minimum Data Set (MDS) coordinator and Interdisciplinary Team (Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Social Worker) by the RDCR on accurate coding of Special Treatments, Procedures, and Programs on MDS assessments prior to submission. The education was completed by 8/20/25. New facility Minimum Data Set (MDS) nurses and Interdisciplinary Team (IDT) members and staff not educated by 8/20/25 will be educated upon hire and prior to working their first shift. 4.The Regional Director of Clinical Reimbursement (RDCR), Director of Nursing, or designee will audit 5	08/22/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0641 SS = D	Continued from page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the area of Special Treatments, Procedures, and Programs regarding Chemotherapy for 1 of 19 residents reviewed for accuracy of assessment (Resident #9). The findings included: Resident #9 was admitted to the facility on 5/21/2024 with diagnoses which included colorectal cancer and heart failure. A nursing note dated 6/24/2025 at 5:18 PM indicated Resident #9 began chemotherapy every 2 weeks, starting on 6/24/2025. An Oncologist note dated 8/5/2025 indicated Resident #9 had a chemotherapy infusion pump placed for a 2-day continuous infusion with pump removal in 2 days. A nursing progress note dated 8/5/2025 at 3:50 PM stated Resident #9 returned to the facility after her oncology appointment with a chemotherapy infusion pump currently in use, secured and taped to her chest. The quarterly Minimum Data Set (MDS) assessment dated 8/6/2025 indicated Resident #9 was cognitively intact. Under section O-Special Treatments, Procedures, and Programs the resident was not coded as receiving chemotherapy while a resident and within the last 14 days. On 8/20/2025 at 11:22 AM an interview with the Regional Minimum Data Set (MDS) Coordinator, MDS Coordinator #1 and MDS Coordinator #2 revealed they obtained Resident #9's assessment information from the daily clinical meetings, medical record progress notes and physician consult notes. The Regional MDS Coordinator stated the MDS was coded incorrectly. She stated the information	F0641	Continued from page 1 resident MDS assessments to ensure Special Treatments, Procedures and Programs (Section Items O0110A-C) are coded correctly, twice weekly for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for four (4) weeks. Deficient practices identified in these audits will be corrected immediately. The results of this audit will be presented by the Minimum Data Set coordinator (MDS) during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance. 5. Date of compliance: 8/22/25	

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F0641 SS = D	Continued from page 2 was missed when the assessment was completed. On 8/21/2025 at 2:21 PM an interview with the Interim Director of Nursing revealed she was not involved with the MDS process but knew the MDS Coordinators attended the clinical meetings each morning when the residents were discussed. She stated the MDS should be coded accurately. On 8/21/2025 at 2:38 PM an interview with the Administrator indicated that the MDS should be coded accurately. The Administrator stated nursing should be consulted if the MDS Coordinators had questions regarding a resident's condition or treatments received.	F0641		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to administer insulin pen injection according to directions when the Unit Coordinator failed to wait at least 6 seconds prior to removing insulin pen from Resident #4's skin. This deficient practice occurred for 1 of 5 residents observed for medication administration (Resident #4). The findings included: The "Insulin Pen" policy implementation date 1/7/25 revealed when injecting insulin pen the nurse should: - Cleanse the skin with alcohol pad. - Inject the needle straight at a 90-degree angle to the skin. - Fully depress plunger until the dosing number count back to zero. - While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin.	F0658	1.The facility failed to administer insulin pen injection according to directions when the Unit Coordinator failed to wait at least 6 seconds prior to removing insulin pen from Resident #4's skin. 2.Current facility residents with orders for insulin pens are at risk of being affected by deficient practices. On 8/21/25 the Director of Nursing provided education to the Unit Coordinator on how to administer an insulin pen. On 8/22/25 the Director of Nursing and the Assistant Director of Nursing conducted observations on all shifts to ensure nurses were administering insulin pens correctly. No new issues were found. 3.The following measures have been put in place to ensure the deficient practice does not recur, are as follows: On 8/22/25 the Director of Nursing and the Assistant Director of Nursing provided education to all current facility nurses on how to administer an insulin pen. The education included the following: Cleanse the skin with an alcohol pad. Inject the needle straight at a 90-degree angle to the skin. Fully depress plunger until the dosing number count is back to zero. While still pressing the plunger, keep the needle in the skin for up to 6 to 10 seconds and then remove the needle from the skin. Remove the needle from the pen by turning	08/23/2025

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F0658 SS = D	Continued from page 3 - May use bandage if needed. - Remove the needle from the pen by turning counterclockwise and dispose of the needle in the sharps container. Resident #4 was admitted to the facility on 7/30/24 with diagnoses that included diabetes type 2. A review of Resident #4's July 2025 physician orders included an order for Novolog FlexPen, give 4 units with meals, hold for blood sugar level less than 100. An observation was conducted on 8/21/25 at 12:50 PM with Resident #4. The Unit Coordinator donned a clean pair of gloves and dialed the Novolog insulin pen to 6 Units and discarded 2 Units, leaving 4 Units on the insulin pen dial. The Unit Coordinator cleaned Resident #4's upper posterior right arm with alcohol wipe. Next, she pressed the pen on Resident #4's arm 3 times in 3 different locations on the right upper arm of Resident #4 with the insulin pen. When the Unit Coordinator pressed insulin pen for the third time at a 90-degree angle to Resident #4's skin, pressed the top button on the pen to inject the insulin until the dial registered 0 units. Next the Unit Coordinator immediately removed the pen less than one count. The surveyor observed a clear fluid draining from Resident #4's arm. The Unit Coordinator wiped Resident #4's arm with a dry gauze and disposed of the insulin needle in the sharps container, removed gloves, and applied antiseptic gel to her hands. An interview was conducted on 8/21/25 at 1:07 PM with the Unit Coordinator. The Unit Coordinator stated that she was nervous and was not aware of how long she held the insulin pen to Resident #4's skin after insulin pen registered 0 units. An interview was conducted on 8/21/25 at 2:04 PM with the Director of Nursing (DON). The DON stated that she asked the Unit Coordinator if she held the pen for a few seconds when the insulin pen reached 0. The DON reported that the Unit Coordinator stated she did not count to know how long she held the insulin pen to Resident #4's skin. The DON stated after she reviewed the policy, the Unit Coordinator should not have removed the insulin pen immediately and should have held the insulin pen to Resident #4's skin with the pen	F0658	Continued from page 3 counterclockwise and dispose of the needle in the sharp container. The Director of Nursing or designee is responsible for ensuring nurses are not allowed to work before completing the education. The education has been added to the new hire education for newly hired facility licensed nurses, and the Director of Nursing/designee will ensure they don't work until the education has been completed. 4.The DON, Regional Director of Clinical Services, or designee will complete observations of 5 residents receiving insulin pen injections 3 times a week for four (4) weeks, then 2 times a week for four (4) weeks, then weekly for four (4) weeks. Any deficient practice identified will be corrected immediately. The results of this audit will be presented by the Director of Nursing during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance. 5.Date of compliance: 8/23/25	

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F0658 SS = D	Continued from page 4 at 0 units for at least 6 seconds.	F0658		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications stored in 1 of 3 medication storage rooms (Central Supply). The findings included: An observation of the Central Supply medication storage room was conducted on 8/19/25 at 11:19 AM in the presence of the Unit Coordinator. The following medication was found in the Central Supply room: one box of hemorrhoidal suppositories. The expiration date on the box was July 2025 and contained 12 suppositories. The Unit Coordinator confirmed the expiration date by reading aloud the date printed on the box. An interview with the Unit Coordinator was completed on 8/19/25 at 11:32 AM. The Unit Coordinator stated that	F0761	1. The facility failed to remove 1 box of 12 hemorrhoidal suppositories that expired 7/2025 and were stored in central supply. 2. All residents with orders for hemorrhoidal suppositories are at risk for deficient practice. On 8/19/25 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Nurse Manager completed an audit of all medication carts, medication rooms, and central supply to ensure there were no other expired medications. No other expired medications were found. 3. On 8/19/25 DON and ADON provided education to all licensed nurses and medication aides to check the expiration date on the medication before pulling the medication to be given. They were also educated on who was responsible for checking each medication cart, medication room, and central supply for expired medications daily. The education included: when removing any OTC medication or supplies from the Central supply room verify the expiration date. Before you put it in your cart circle the expiration date. Continue to mark the date opened. Any items you find expired please discard and let Central supply know. On 8/19/25 the DON was informed by the Administrator it is her responsibility to ensure all licensed nurses and medication aides receive the education before working their next shift. Staff will not be able to work until educated. The DON will add the education to the new hire education for licensed nurses and medication aides and ensure it has been completed before being allowed to work their first shift. 4. The Director of Nursing or designee will audit both medication rooms and Central Supply 2 times weekly for 4 weeks and each medication cart 2 times weekly for 4 weeks to ensure there are no expired medications. Any concerns will be addressed immediately. The Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review. Date of compliance is 8/22/25	08/22/2025

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F0761 SS = D	Continued from page 5 all staff who administer medications were responsible for checking medication expiration dates prior to leaving the Central Supply room and before administration of all medications. She also reported that expired medications were disposed of to prevent circulation to residents. An interview with the Central Supply Coordinator on 8/19/25 at 11:34 AM revealed that she expected all staff to check the expiration dates on medications prior to leaving the Central Supply room and dispose of the item if it was expired. The Central Supply Coordinator indicated she checked the Central Supply room monthly to reorder supplies as needed but did not check for expired medication. The interview with the Director of Nursing (DON) on 8/21/25 at 2:04 PM revealed that when a nurse retrieved a medication from the Central Supply room the expiration date was reviewed and if a nurse identified an expired medication, the medication was disposed of immediately. The interview with the Administrator was completed on 8/21/25 at 2:37 PM. The Administrator stated that she expected staff to check the expiration date prior to the medication leaving the Central Supply storage room and discard any expired medication prior to leaving the Central Supply room.	F0761		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing	F0880	1. The Unit Coordinator did not perform hand hygiene prior to donning clean gloves to perform blood glucose fingerstick and insulin injection for Resident #4 and Resident #105. On 8/21/25 the Director of Nursing (DON) re-educated the Unit Coordinator on handwashing and hand hygiene procedures before she was allowed to return to hall. 2. Since proper hand hygiene is essential to prevent infection, all residents have the potential to be affected by the deficient practice. Staff interactions with residents were evaluated to ensure adherence to current infection control standards. This observation was conducted on 8/21/25 and 8/22/25 by the Director of Nursing and the Assistant Director of Nursing to ensure proper hand hygiene procedures were followed during blood glucose fingerstick and insulin injections. No new deficient practice was identified. 3. All nursing staff (facility licensed nurses and CMAs) will be educated by 8/22/25 on hand hygiene policy. This includes when and how to perform handwashing or use alcohol-based hand rubs in accordance with CDC guidelines and facility policy,	08/23/2025

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F0880 SS = D	Continued from page 6 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880	Continued from page 6 with a focus on hand hygiene during direct care, wound care, and medication or treatment administration. The facility reinforced the expectation that hand hygiene must be performed before and after all applicable resident contact and care procedures. The Director of Nursing is responsible for ensuring nursing staff are not allowed to work before completing the education. The education has been added to the new hire education for newly hired facility licensed nurses and CMAs, and the Director of Nursing/designee will ensure they don't work until the education has been completed. 4. Monitoring to ensure the plan is effective: The staff development nurse or designee will perform 5 random observations per week for 4 weeks, with 2 observations of nursing staff performing blood sugar fingerstick and insulin injections. After the initial 4 weeks, the staff development coordinator or designee will complete 3 observations of hand hygiene per week, for 8 additional weeks, for a total of 12 weeks of monitoring. Observations with any required interventions or re-education will be completed and documented by the staff development coordinator to ensure compliance with infection control standards. The findings of the observations of hand hygiene will be reviewed at least monthly by the Infection Preventionist and Director of Nursing during the monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure compliance is achieved and sustained without the need for further corrective action. The date of compliance is 8/23/25	

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F0880 SS = D	Continued from page 7 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when the Unit Coordinator did not perform hand hygiene prior to donning clean gloves to perform blood glucose fingerstick and insulin injections for Resident #4 and Resident #105. This deficient practice occurred for 1 of 6 staff members observed for infection control practices (Unit Coordinator). The findings included: The “Hand Hygiene” policy implementation date 1/2/25 revealed all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. “Hand hygiene” was defined as cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based rub. The policy also revealed staff should perform hand hygiene for the following: - Before and after direct resident contact - Upon and after coming in contact with a resident’s intact skin - After contact with a resident’s mucous membranes and body fluids - After removing gloves or aprons Observation #1 was conducted on 8/21/25 at 12:19 PM while Resident #105 received an insulin injection. The Unit Coordinator was observed entering Resident #105’s room wearing a gown, gloves and carrying a plastic box that contained alcohol wipes, insulin vial and glucometer supplies. The Unit Coordinator stated she had to exit the room to obtain an insulin syringe. The Unit Coordinator removed her gown, gloves, and disposed of them in the trash before exiting the room. The Unit Coordinator retrieved 4 insulin syringes from the medication cart and placed them in the clear plastic supply box. The Unit Coordinator returned to Resident #105’s room and donned gown and gloves without performing hand hygiene. Then the Unit Coordinator wiped the insulin vial with an alcohol wipe and used a syringe to draw up 15 Units of Humalog insulin. The Unit Coordinator cleaned the posterior upper right arm	F0880		

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F0880 SS = D	Continued from page 8 of Resident #105 with alcohol wipe and administered the insulin injection. The Unit Coordinator removed her gown, gloves and returned to medication cart and applied antiseptic gel to hands. A second observation was conducted on 8/21/25 at 12:50 PM with Resident #4. The Unit Coordinator obtained the glucometer supply box for Resident #4, applied antiseptic gel to both hands and applied clean gloves. The Unit Coordinator wiped Resident #4's right ring finger with alcohol wipe, pricked the finger with a lancet to obtain blood sample. The Unit Coordinator applied a sample of Resident #4's blood to the glucometer test strip. The glucometer reading resulted in an error reading. The Unit Coordinator removed her gloves and returned to the medication cart to retrieve another test strip for the glucometer. She then donned clean gloves without performing hand hygiene and cleaned Resident #4's right ring finger with alcohol wipe, pricked the finger with the lancet, wiped the finger with a dry gauze, and collected the blood sample with the glucometer. The Unit Coordinator disposed of the lancet, test strip and gloves. She then donned a clean pair of gloves without doing hand hygiene and before administering the insulin. An interview was conducted on 8/21/25 at 1:07 PM with the Unit Coordinator. The Unit Coordinator stated that she was nervous and forgot to perform hand hygiene prior to putting on clean gloves prior to insulin injection for Resident #105 and prior to glucometer test and insulin injection for Resident #4. An interview with the Infection Preventionist on 8/21/25 at 1:06 PM revealed that the Unit Coordinator should have performed hand hygiene after removing gloves while insulin injection for Resident #105 and prior to glucometer test and insulin injection for Resident #4. The Infection preventionist stated that staff were educated on hand hygiene and glucometer testing July 2025 and the Unit Coordinator attended the training. An interview was conducted on 8/21/25 at 2:04 PM with the Director of Nursing (DON). The DON stated the Unit Coordinator was nervous and should have performed hand hygiene after removing gloves when performing insulin injection for Resident #105 and prior to glucometer test and insulin injection for Resident #4.	F0880		