STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Health & Rehabilitation Center	1735 Toddville Road Charlotte, NC 28214

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on record review, and staff, resident and family member interviews, the facility failed to develop and implement effective discharge planning that ensured a resident would have the necessary durable medical equipment when she was discharged home to include a hospital bed, gel bed overlay with mattress, half side rails, a trapeze bar, and oxygen supplies for 1 of 4 residents reviewed for discharge (Resident #1). Resident #1 stated she was not provided with equipment for oxygen therapy and would get short of breath, and it would wake her up. Resident #1 reported she would cough, and it made her throw up at night. In addition, Resident #1 indicated that the hospital bed was not delivered, and she was sleeping in a recliner due to the shortness of breath which resulted in edema in her ankles and worsening of gastroesophageal reflux disease (GERD) symptoms. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses including GERD, sleep apnea, and rhabdomyolysis (a serious condition caused by a direct or indirect muscle injury and could lead to serious complications such as kidney failure). A review of physician order dated 1/22/25 revealed Resident #1 received oxygen therapy at two liters per minute via nasal cannula, every day and night shift. An admission Minimum Data Set (MDS) on 1/29/25 revealed Resident #1 was cognitively intact. Resident #1 was not coded for oxygen use. The MDS was coded for Resident #1 to discharge back to the community. A review of Resident #1's Treatment Administration Record (TAR) revealed she received oxygen at two liters per minute via nasal cannula, every day and night shift from 1/22/25 to 2/5/25. A review of a physician order/note dated 2/5/25 and signed by the previous Medical Director revealed Resident #1 needed the use of durable medical equipment (DME) in her home. The equipment included a semi-electric hospital bed, a gel overlay for the mattress and a trapeze bar. The order described Resident #1 as having severe back pain and needed frequent changes in body position to alleviate the pain caused by arthritis. Resident #1 was described in the note as having a compromised circulatory status, therefore requiring pressure reducing support surface to treat and prevent skin breakdown. Resident #1 also needed a trapeze bar to get in and out of bed. The order did not include oxygen supplies. (continued on next page)

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

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F 0660 Level of Harm - Actual harm Residents Affected - Few	A review of an itemized physician's order form dated 2/5/25 and signed by the previous Medical Director included a semi-electric hospital bed, wheelchair, gel overlay, a mattress, half bed rails, and a trapeze bar. The order did not include oxygen supplies. A review of a nursing progress note written by Nurse #1 dated 2/6/25 revealed Resident #1 was given patient discharge instructions. Nurse #1 reviewed medications with Resident #1 who voiced understanding. She was discharged with medications and prescriptions. A review of the discharge summary dated 2/6/25 and signed by Nurse #1 revealed Resident #1 was discharged home with home health services and needs for a hospital bed and walker. The discharge summary did not include the need for any oxygen supplies and did not indicate Resident #1's use of oxygen at the facility. The discharge summary did not have contact information for the durable medical equipment provider and listed a bed and walker as the equipment needed by Resident #1. A telephone interview with Nurse #1 on 3/19/25 at 2:39 PM revealed she discharged Resident #1 home on 2/6/25. She stated the SW would order any durable medical equipment for any residents discharging home. She stated she printed a discharge summary for Resident #1 and went through her medications with her. Nurse #1 stated if oxygen was listed on the summary, she would have discussed it with Resident #1. She stated nursing would typically fill out the device section of the assessment. Nurse #1 explained if oxygen was not checked off on the discharge summary list for Resident #1, it would not have been ordered for the discharge. A telephone interview with a DME Company Representative on 3/19/25 at 12:47 PM revealed Resident #1 had not received her equipment in her home after her discharge. She stated Resident #1's family had called the equipment company many times inquiring why the bed and other equipment had not been delivered. A second telephone interview with a DME Company Representative on 3/20/25 at 9:08 AM revealed she spoke to Resident #1's family member for the first time on 3/10/25 but the family member had placed many calls to the call center requesting information about Resident #1's equipment. She stated the facility originally did not fax over the needed information to complete the DME order to include the medical need for the supplies requested. The DME Company Representative explained the DME requested was for the bed and the bed accessories. She did not know Resident #1 needed oxygen therapy, but added they would be able to get her the supplies she needed if the facility would send over an order and medical need for the oxygen. The DME Company Representative stated no DME, or supplies had been delivered to Resident #1 yet as they were waiting on the documents requested from the facility. A telephone interview was conducted with Resident #1's family member on 3/19/25 at 1:50 PM. She stated Resident #1 had not yet received the hospital bed or any equipment that came with the bed. The Family Member indicated Resident #1 did receive a walker and a bedside commode when she was discharged from the facility. She understood from the DME company that the correct information needed for the DME including oxygen supplies was not given by the facility during the discharge process. The Family Member stated she called the call center at the durable medical equipment company many times. She stated the DME Company Representative was helping her to get the documentation needed for the equipment from the facility. (continued on next page)

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F 0660 Level of Harm - Actual harm Residents Affected - Few	A second telephone interview with Resident #1's family member on 3/19/25 at 2:12 PM. She stated Resident #1 had continuous oxygen in the hospital prior to her admission at the facility. She revealed the facility did not provide Resident #1 a portable oxygen tank after discharge, and she wore oxygen every day during her stay at the facility. A telephone interview with Resident #1 on 3/20/25 at 10:03 AM revealed she did not have her hospital bed, the gel overlay, the trapeze bar, or oxygen as of 3/20/25. She stated when she was in the facility, she had oxygen because when she was sleeping, her oxygen level would go down. Resident #1 stated she was not sent home with any oxygen equipment from the facility, and when she slept, she would get short of breath, and it would wake her up. Resident #1 reported she would cough, and it made her throw up at night. Resident #1 explained she had been sleeping in a recliner because of her shortness of breath and her GERD. She stated that because she has been in her recliner to sleep, her ankles were swollen, and they were not before when she was sleeping in an adjustable bed at the facility. Resident #1 stated her GERD has worsened because of not being able to sleep in an adjustable bed. Resident #1 indicated she had not been hospitalized since her discharge from the facility. An interview with the Social Worker (SW) on 3/19/25 at 2:19 PM revealed Resident #1 discharged home on 2/6/25 with orders for home health services and equipment that included a hospital bed and accessories to include a trapeze bar, mattress and overlay and side rails. She stated Resident #1's discharge plan included a bed with other accessories and a walker. The SW indicated she created the DME order on 2/5/25 and sent over the paperwork in the ordering portal to start the ordering process with the DME company. The SW recalled on 3/10/25, Resident #1's family member called and stated they had not received the bed. The SW stated the DME company needed documentation that explained the necessity of the bed to fulfill the order. She stated she sent the information to the durable medical equipment company on 3/17/25 and she received a message from the contact at the durable medical equipment company on 3/19/25 that the documentation was approved. The SW explained she was not aware Resident #1 had an order for oxygen in the facility or needed oxygen therapy after discharge. The SW revealed she did not review residents' orders before discharge and nursing would have been responsible for alerting her to Resident #1's need for oxygen. She stated discharges were discussed during the morning meeting at the facility. The SW further stated she did not follow up with Resident #1 after her discharge from the facility. She explained she made the official request for DME supplies based on the reports given to her from other departments during the morning meeting. An interview with the Unit Manager on 3/20/25 at 9:51 AM revealed he could not recall specifics about Resident #1's care but stated typically discharges were discussed in the morning meeting. He stated supplies needed for a resident's discharge would be discussed and the SW would order anything needed for the discharge. The Unit Manager indicated nursing would typically inform the SW if oxygen was needed. A telephone interview with the previous Medical Director on 3/20/25 at 11:55 AM revealed he had written the discharge orders for Resident #1 but explained he did not specially recall Resident #1 as he was temporally filling in as Medical Director for the facility. He stated if a resident used oxygen in a facility and still had the need for oxygen, then oxygen therapy should have been part of the discharge plan. The previous Medical Director explained that if he signed a physician's order for DME for a resident before discharge, then the equipment was necessary. (continued on next page)

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F 0660 Level of Harm - Actual harm Residents Affected - Few	An interview with the Administrator on 3/20/25 at 11:04 AM occurred. She stated Resident #1 did not receive her bed and DME due to the need for additional information to document Resident #1's need for the equipment to fulfill the order. The Administrator indicated the facility reviewed discharges during the clinical part of their morning meeting but did not recall Resident #1's discharge discussion. She stated during this meeting all DME was reviewed for each resident discharging. The Administrator stated Resident #1's needs for oxygen should have been reviewed before she was discharged from the facility. She explained the SW should have followed up with Resident #1 before she left the faciity on her needs. The Administrator explained the facility had implemented a plan in response to the discharge concerns with Resident #1 to improve coordination with DME and home health services for residents discharging home from the facility. The facility presented a plan of correction that was not accepted by the State Survey Agency. The facility failed to provide evidence of the audits being completed at the time the plan was completed. The interview with the SW on 3/19/25 revealed that she was not calling all discharges as stated she would in the plan but only called the residents who left against medical advice or had a lot of concerns and indicated that she was just recently been given this directive from her Regional Consultant. Furthermore, the ongoing monitoring failed to include the names of the residents that were audited upon discharge and what equipment was needed and verified to have been delivered to the discharged resident.