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	10/23/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on record review, observations and staff interviews, the facility failed to maintain a resident's privacy by not providing full visual privacy during tracheostomy (hole that surgeons make through the front of the neck and into the windpipe) care for 1 of 1 resident (Resident #187) reviewed for personal privacy. The reasonable person concept was applied as a reasonable person would expect privacy in their home when being cared for. The findings included: Resident #187 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed he had severe cognitive impairment and was coded for tracheostomy care. During a continuous observation of tracheostomy care from inside Resident #187's room on 10/23/2024 from 11:00 AM until 11:18 AM, Nurse # 1 and Nurse # 2 left Resident #187's door open to the hallway while they were cleaning the tracheostomy site, performing suctioning, and changing the tracheostomy cannula. Resident #187 was in a private room and there was no privacy curtain in the room. While standing at Resident #187's bedside, observing Nurse #1 and Nurse #2 provide care for the resident the hallway could easily be visualized. There was nothing in the room that would obstruct the view of the resident receiving care from the hallway. An interview was completed on 10/23/2024 at 11:21 AM with Nurse # 1 where she reported Resident #187's door should have been closed for his privacy. Nurse # 1 went on to say she was not sure why she did not close the door except that she just forgot. During an interview with Nurse #2 on 10/23/2024 at 11:23 AM he reported the door to Resident #187's room should not have been opened while they were providing care, but he forgot to close it or even remind Nurse #1 to close it. An interview was conducted on 10/23/2024 at 11:32 AM with the Director of Nursing (DON) where she explained there were no privacy curtains in the private room, but she expected the resident's door to be closed any time care was being provided to maintain their privacy. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/2024 at 12:33 PM an interview was completed with the Administrator. During the interview the Administrator reported she expected staff to close the door when providing care to maintain resident privacy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based upon observation, record review, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1of 1 resident (Resident #187) reviewed for special services. Findings included: Resident #187 was admitted to the facility on [DATE] with the following diagnoses: respiratory failure with hypoxia, pneumonia, and tracheostomy status. A review of Resident #187's admission Minimum Data Set (MDS) dated [DATE] showed the resident had severe cognitive impairment, aphasia and respiratory failure. The MDS also revealed Resident #187 was receiving oxygen, needed tracheostomy care, and was on invasive mechanical ventilation. Review of Resident #187's care plan dated 10/18/2024 revealed he was at risk for complications secondary to a tracheostomy related to respiratory failure. Interventions included: tracheostomy care as needed, notify the Physician of any respiratory complications, and suction as needed. There was no care plan for invasive mechanical ventilation. A review of Physician orders dated 10/7/2024 through 10/20/2024 revealed there were no orders for invasive mechanical ventilation. On 10/20/2024 at 2:21 PM Resident #187 was observed lying in bed, alert with eyes open. A tracheostomy was in place with oxygen running. There was no evidence of invasive mechanical ventilation. An interview was completed with Nurse #3 on 10/22/2024 at 2:22 PM. During the interview Nurse #3 looked at Resident #187's electronic medical record and reported while he was in the hospital he did receive invasive mechanical ventilation, but was weened down from the ventilator prior to admission to the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on observations, record reviews, and staff interviews, Nurse #1 failed to follow the procedure for tracheostomy (hole that surgeons make through the front of the neck and into the windpipe) care when she did not use the sterile gloves from the sterile tracheostomy kit when cleaning the tracheostomy site and changing the inner canula. In addition, the facility failed to have a physician order for continuous oxygen for Resident #187. This deficient practice occurred for 1 of 1 resident requiring tracheostomy care (Resident #187). The findings included: a. Review of the facility's procedure guide for Tracheostomy Care read in part, perform hand hygiene and apply clean /sterile gloves for suctioning and other Personal Protective Equipment (PPE) if not already completed. Hyper-oxygenate resident for 30 seconds or ask resident to take 5-6 deep breaths then suction tracheostomy. Before removing gloves, remove the soiled dressing and discard. Perform hand hygiene again and prepare equipment on the bedside table as follows: Open sterile tracheostomy kit and prepare dressings and cleaning supplies. Open sterile tracheostomy dressing package. Unwrap sterile basin and pour normal saline into it. Open small sterile brush package and place aseptically into sterile basin. Prepare tracheostomy fixation device. Open inner cannula package. Apply sterile gloves and keep dominant hand sterile throughout procedure. Resident #187 was admitted on [DATE] with the following diagnoses: respiratory failure with hypoxia, pneumonia and tracheostomy status. Review of orders dated 10/7/2024 showed the following, tracheostomy care every shift and as needed. Clean or change the inner cannula as applicable. Suction tracheostomy as needed for excess secretions. A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #187 had severe cognitive impairment and required tracheostomy care. Review of the care plan dated 10/18/2024 showed a problem that the Resident was at risk for complications secondary to a tracheostomy related to respiratory failure. There was a goal for the Resident to be free from complications related to having a tracheostomy. Interventions included, observe for signs and symptoms of respiratory complications including infection and or respiratory blockage or mucous plug, refer to pulmonologist as needed, suction as needed, and tracheostomy care per order. A continuous observation of tracheostomy care was conducted on 10/23/2024 from 11:00 AM to 11:21 AM. Before the procedure, Nurse #1 performed hand hygiene and applied gloves. Nurse #1 proceeded to open the sterile tracheostomy cleaning kit and while opening the kit an item fell to the floor. Nurse #1 retrieved another tracheotomy cleaning kit from the PPE container hanging on the Resident's door. Nurse #1 failed to remove gloves, perform hand hygiene, or apply new gloves before continuing to open the rest of the items in the tracheostomy kit. Prior to cleaning the tracheostomy site and changing the inner cannula, Nurse #1 failed to apply the sterile gloves from the tracheostomy kit or keep one hand sterile through the procedure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed on 10/23/24 at 11:22 AM with Nurse #1. During the interview Nurse #1 stated the sterile gloves should have been applied and changed anytime the sterile field was broken. During an interview on 10/23/24 at 11:32 AM with the Director of Nursing (DON) she reported she expected Nurse #1 to follow the policy and procedures, including using the sterile gloves provided in the tracheostomy kit when performing tracheostomy care. On 10/23/24 at 12:06 PM an interview was completed with the Infection Preventionist (IP). During the interview the IP stated Nurse #1 should have followed the policy and procedure for tracheostomy care as well as changed her gloves and washed her hands after getting a new tracheostomy cleaning kit. The IP further explained there would be additional education on proper tracheostomy care and hand hygiene. An interview was completed with the Administrator on 10/23/24 at 12:33 PM where she reported she expected staff to follow policies and procedures for tracheostomy care. b. A review of Resident #187's physician orders dated 10/7/2024 through 10/21/2024 revealed orders were in place for tracheostomy care. There were no orders for oxygen use. An observation on 10/20/2024 at 2:21 PM showed Resident #187 was lying in bed with oxygen set to 3 liters (L)/minute. On 10/22/2024 at 8:53 AM Resident #187 was observed lying in bed with oxygen flowing into the tracheostomy and set on 3L/minute. An interview was completed on 10/22/2024 at 2:22 PM with Nurse #3. During the interview Nurse #3 looked at Resident #187's orders and was unable to find any orders related to oxygen flow rate, however she was able to find the oxygen settings in Resident #187's discharge paperwork. Nurse #3 went on to say if there was no order in place the Nurse Practitioner (NP) or Physician needed to be called for clarification orders. During an interview with the 200 Hall Unit Manager on 10/22/2024 at 2:32 PM she looked at the Physician orders and electronic medical record (eMAR) for Resident #187 and was not able to find orders for oxygen use. The Unit Manager stated there should have been orders in place for the oxygen flow rate. An interview was completed with the Director of Nursing (DON) on 10/22/2024 at 2:43 PM. During the interview the DON looked through Resident #187's eMAR and was not able to find orders for oxygen use, including flow rate. The DON reported there should be orders in the system for oxygen flow rate and the humidifier on the O2 concentrator. The DON further explained Resident #187 was a newly admitted resident and new admission orders were reviewed by several members of the nursing team, including the Unit Managers, but somehow the orders for Resident #187's oxygen had been missed. During an interview with the Administrator on 10/23/2024 at 12:33 PM she reported her expectation was for all orders for any newly admitted residents to be discussed during clinical meetings and any discrepancies needed to be discussed and the Physician notified. The Administrator went on to say there should have been orders in place for Resident #187's oxygen.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on observations, record review, review of Resident Council minutes, and resident and staff interviews, the facility failed to follow their planned menus for 1 of 1 sampled resident reviewed for preferences (Resident #65). The deficient practice had the potential to affect other residents who received food from the kitchen. The findings included: Resident #65 was admitted to the facility on [DATE], discharged and readmitted on [DATE] with the following diagnoses: end stage renal disease (ESRD), dependence upon dialysis, vitamin deficiency, and gastroesophageal reflux disease (GERD). A review of the admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #65 was cognitively intact. The MDS also indicated Resident #65 only needed set-up assistance from staff with eating. Review of #65's Physician orders dated 10/8/2024 showed a dietary order for a renal diet with regular texture and thin liquids. A review of Resident #65's most recent care plan dated 8/16/2024 revealed Resident #65 was at risk for weight loss or malnutrition related to chronic diseases including GERD, ESRD, and dependence upon dialysis. The goal in place was for Resident #65 to have optimal nutrition and hydration status through the review period. Interventions included therapeutic diet as ordered, encourage to eat, and monitor meal intakes. Review of Resident Council minutes dated 5/7/2024 showed residents did not feel like the menus were being followed and they were not receiving what they ordered. An additional review of Resident Council minutes dated 7/3/2024 revealed residents were concerned that they were not being informed when substitutions were being made to meals. Resident Council notes dated 8/13/2024 indicated residents were concerned because they were not getting what they were selecting on their menus. On 10/20/2024 at 10:40 AM an interview was completed with a [NAME] Aide where she reported food was delivered on Mondays and sometimes the facility received what they ordered and sometimes they did not. She went on to say the Dietary Manager placed the orders and then someone above her changed the order due to the budget. An interview with Resident #65 on 10/20/2024 at 12:23 PM revealed meal tickets did not usually match what was served. The interview further revealed Resident #65 felt as if she did not ever receive enough protein as she rarely received any meat at breakfast. Resident #65 went on to say she was not always offered the chance to make choices regarding the menu, because staff would serve what they wanted to serve. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of Resident #65's lunch tray on 10/20/2024 at 12:27 PM showed she had mixed greens, black eyed peas, a meat that the resident reported as baked chicken, and pineapple tidbits. An observation of Resident #65's lunch meal ticket indicated she should have received buttered green beans, black eyed peas, baked chicken, and apple pie. An additional observation was completed on 10/22/2024 at 8:45 AM of Resident #65's meal ticket and breakfast tray. Resident #65's tray had oatmeal and scrambled eggs. A review of the meal ticket revealed there should have also been a sausage patty and a cup of milk on the tray. Resident #65 reported she received neither of those items. An observation of the breakfast menu outside of the dining room on 10/23/2024 at 8:27 AM showed there was supposed to be a sausage patty with biscuit and country gravy and a side of grits. Observation and interview of Resident #65's breakfast meal ticket on 10/23/2024 at 8:30 AM revealed the resident had received eggs, toast, and cereal. Resident #65 reported she did not receive a sausage patty or gravy for breakfast. During an interview on 10/22/2024 at 10:39 AM with Nurse Aide (NA) #1 she explained resident menus were supposed to be filled out the day before and the only time they were informed of any changes in the menu was when they would open the resident's meal tray during set-up. An interview was completed on 10/22/2024 at 10:59 AM with NA #2 where she reported staff would not be told about any menu changes and would learn about the changes when the meal tray was opened. NA #2 further explained that some residents would receive breakfast meats, and others would not because the kitchen did not always have protein available. An interview with the Registered Dietician (RD) was completed on 10/22/2024 at 8:59 AM. During the interview the RD reported she signed off on a log after the fact for any substitutions. She went on to say the Dietary Manager was able to make the substitutions if the kitchen was out of what they were supposed to have. The RD also reported any substitutions that were made to the menu had to be posted outside of the dining room. The RD further explained the kitchen did not have anything that could have been substituted for the sausage because the company that delivered the food order was out of sausage. An interview was conducted on 10/22/2024 at 9:28 AM with the Dietary Manager. During the interview the Dietary Manager reported the meal tickets were not changed to show substitutions and the only way a resident would know if there had been a change would be for them to come to the dining room to look at the menu. An interview was completed on 10/23/2024 at 12:35 AM with the Administrator where she explained her expectations were that the residents be informed of any menu changes and the kitchen to follow their policies and procedures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49366 Based on record review, observations and staff interviews, the facility failed to label and date leftover food items stored for use, keep a food storage area clean and orderly, and failed to dry serving trays prior to stacking. These practices occurred in 1 of 7 reach-in coolers, 1 of 1 walk-in freezer, 1 of 1 dry goods storage area, and had the potential to affect food served to residents. The findings included: An initial tour of the main kitchen occurred 10/20/24 at 10:26 AM. The following concerns were identified: a. A bag of leftover frozen French fries was observed in the walk-in freezer not dated. b. Food items in the reach-in coolers that were open and not labeled with a use by date included: -three resealable plastic bags of cut watermelon -one gallon tub of sweet pickle relish -gallon tub of blue cheese dressing -five-pound tub of sour cream -14 ounce can of whipped cream c. Four disposable bowls of vanilla pudding on a tray, not covered or dated in the reach-in cooler were observed. d. Three bags of hamburger buns with manufacturer's best by of 9/14/24 were observed in the dry storage room. e. 51 clean serving trays were observed wet-nested in the dishwashing area on a tray-holding cart. All 51 trays were visibly wet and wet to the touch. An interview with [NAME] Aide #1 on 10/20/24 at 10:40 AM revealed the trays were stacked wet due to limited space in the dishwashing area. An interview with the Dietary Manager (DM) on 10/22/24 at 9:28 AM revealed she had been in the DM role for about a month. She stated she was not aware of the wet nested trays, the items that were not labeled, and items stored past the use by date. An interview with the Administrator on 10/23/24 at 12:35 PM revealed she had the expectation that the kitchen staff and managers followed their policies and procedures.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49366 Based on observations and staff interviews the facility failed to remove loose garbage, food, and debris from around 2 of 2 trash receptacles located outdoors behind the kitchen. This practice had the potential to impact sanitary conditions and attract pests/rodents. The findings included: An observation of the outdoor trash receptacle area on 10/20/24 at 10:52 AM revealed eight sets of used disposable gloves and one used sandwich bag with food debris in it on the ground outside of the receptable. One garbage bag was found on the sidewalk leading to the trash receptacle area that was open with debris and spaghetti noodles. During the observation the receptacle door on one trash receptacle was noted to be open and the lid of the trash receptacle caved into the dumpster, weighed down by garbage bags. An interview with Maintenance Assistant on 10/22/24 09:28 AM revealed the housekeeping and maintenance departments were responsible for keeping the trash receptacle area clean. He stated the area was cleaned each morning and trash and debris was removed from night shift. An interview with the Administrator on 10/23/24 at 12:35 PM revealed she expected the trash receptacle area to be maintained according to the facility's policies and procedures.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 49366 Based on observations and staff interviews, the facility failed to maintain the food steamer, which leaked water onto the floor in the main kitchen, in safe operating condition. Findings included: An observation made on 10/20/24 at 10:43 AM revealed a large puddle of water under the food steamer next to the gas stove adjacent to the food preparation area. Water was observed dripping out a plastic pipe on the back of the appliance. The pipe was not located above the floor drain and a large puddle of water was observed on the kitchen floor. An interview with [NAME] Aide #1 on 10/20/24 at 10:42 AM revealed the kitchen staff verbally reported the leaking pipe from the food steamer to Maintenance staff multiple times in the previous weeks and the water was still leaking on the kitchen floor. An interview with Dietary Manager (DM) on 10/22/24 at 9:28 AM revealed she was not aware of the leaking pipe from the food steamer. An interview with the Maintenance Assistant on 10/23/24 at 9:48 AM revealed he was not aware of the leaking pipe from the food steamer. He stated the facility used an online maintenance tracking system. He stated staff knew to enter a concern in the system, and Maintenance staff would respond to the need. He stated if there was an urgent need, staff knew to verbally alert the Maintenance staff, and they would immediately respond. An interview with the Administrator on 10/23/24 at 12:35 PM revealed she was not aware of the leaking pipe under the steamer appliance, and she had the expectation that the kitchen staff and managers followed their policies and procedures to maintain equipment and report any concerns to Maintenance staff.