STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. Building B. Wing	09/19/2025

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

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Medical Director interviews, the facility failed to implement their abuse policy and procedure in the areas of reporting to the state survey agency and investigating an injury of unknown source for a dependent resident who sustained an acute non-displaced proximal (upper) tibia (larger inner shinbone) and fibula (small outer shinbone) fracture and an acute right tibia fracture for 1 of 3 residents reviewed for accidents (Resident #1).The findings included:A review of the facility's abuse, neglect, and exploitation policy and compliance with reporting alleged violations policy and procedure dated January 2025 indicated the following: - It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources to appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. - Injuries of unknown source include circumstances when both the following conditions are met: 1. The source of the injury was not observed by any person or could not be explained by the resident. 2. The injury is suspicious because of the extent of the injury, location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time. - The Administrator or designee will notify the appropriate agencies, in the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion.-Immediate investigation is warranted when suspicion of abuse neglect or exploitation or reports of abuse neglect or exploitation occur. -Written procedures for investigations include:1. Identifying and interviewing all involved persons including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 2. Focusing the investigation on determining if abuse, neglect or exploitation and/or mistreatment has occurred, the extent and cause, and providing complete and thorough documentation of the investigation. Resident #1 was admitted to the facility on [DATE]. The significant change Minimum Data Set, dated [DATE] revealed Resident #1 was severely cognitively impaired and dependent on staff for assistance with activities of daily living (ADL). The radiology report dated 8/28/25 at 1:14 PM indicated an x-ray obtained of Resident #1's left knee revealed an acute non-displaced proximal (upper) tibia (larger inner shinbone) and fibula (small outer shinbone) fracture. The emergency department (ED) report dated 8/28/25 revealed x-rays obtained in the ED indicated Resident #1 had an acute comminuted (broken in multiple pieces) mildly displaced (bone fragments are only slightly out of position) left tibia and fibula fracture and an acute right tibia fracture. The ED report noted Resident #1 was non-ambulatory, wheelchair bound, required the use of a mechanical lift for all transfers and that the source of the injury was unknown and that the facility denied any recent falls. A review of the facility reported incidents from 8/22/25 through 9/17/25 indicated no initial allegation report or 5-day investigation report was completed or submitted to the state agency regarding Resident #1's injury of unknown source. During a phone interview with the interim DON on 9/18/25 at 4:57 PM she stated she was notified immediately on 8/28/25 when Resident #1's x-ray results were received and indicated a left tibia and fibula fracture. She stated the ADON assisted her with interviewing staff and there were no reports of Resident #1 having an accident or incident that would have caused a fracture. The interim DON stated Resident #1 had a history of fractures and osteoporosis and due to no reports of a fall or trauma to her leg they determined the fracture was pathological. A phone interview with the Medical Director indicated she was notified on 8/28/25 that Resident #1 obtained a left tibia and fibula fracture and was transferred to the ED for further evaluation. She stated on 8/29/25 she reviewed Resident #1's medical record and due to her history of fractures, diagnoses of osteoporosis and osteopenia and no reports of a fall or trauma to her leg she determined the fracture was pathological in nature. The Medical Director indicated she did not review Resident #1's ED or hospital records nor was she aware of the right tibia fracture however Resident #1 having bilateral leg fractures made it more evident that the fractures were pathological. An interview conducted with the Administrator on 9/17/25 at 2:30 PM revealed she was notified immediately on 4/28/25 of Resident #1's x-ray results and that she had a leg fracture. She indicated interviews were conducted with nursing staff to determine if there was an incident or accident that occurred to cause the fracture, and no incidents or accidents were reported. She stated on 4/29/25 the Medical Director reviewed Resident #1's medical record and determined the fracture was pathological. She stated they determined the source of the injury was pathological, so an initial allegation report was not submitted to the state agency nor was a 5-day investigation report completed.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a safe transfer for 1 of 3 residents reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, dependence on renal dialysis, and dementia. The resident care guide dated 8/27/24 indicated Resident #1 required 2-person assistance and the use of a mechanical lift for transfers. The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was severely cognitively impaired and dependent on staff for assistance with activities of daily living (ADL) including transfers. A phone interview conducted with Nurse Aide (NA) #1 on 9/16/25 at 8:41 AM revealed she was Resident #1's Responsible Party (RP) and worked at the facility on night shift (7:00 PM to 7:00 AM). She stated she was not assigned to Resident #1 when she worked but would check on her and provide care as needed. She revealed on 8/26/25 at approximately 8:00 PM Resident #1 was complaining of leg pain during incontinence care. She stated Nurse Practitioner (NP) #1 was making rounds the next morning and assessed Resident #1 due to her complaints of leg pain. NA #1 revealed after NP #1 assessed Resident #1, NA #2 assisted her with transferring Resident #1 with the mechanical lift from the bed to the wheelchair. A phone interview was conducted with NA #2 on 9/17/25 at 7:45 AM. NA #2 revealed she was assigned to Resident #1 on 8/26/25 from 7:00 PM to 7:00 AM on 8/27/25. She stated NA #1 provided incontinence care for Resident #1 at approximately 8:00 PM and told her she would be back at the end of her shift to assist Resident #1 with morning care. NA #2 stated on the morning of 8/27/25 she did not assist NA #1 with transferring Resident #1 using the mechanical lift. A follow-up phone interview was conducted with NA #1 on 9/17/25 at 9:34 AM. She stated on 8/27/25 she transferred Resident #1 from the bed to the wheelchair with the mechanical lift without a second person. She stated she wanted to ensure Resident #1 was transferred gently due to her leg pain and felt she would accomplish this by transferring her alone. NA #1 revealed the transfer was successful and without incident. She indicated the facility's policy was to have a second person when transferring a resident with the mechanical lift and she should have requested for another staff member to assist her with the transfer. An interview with the Assistant Director of Nurse (ADON) on 9/16/25 at 4:26 PM revealed she was aware that NA #1 reported on the morning of 8/27/25 NA #2 assisted her with transferring Resident #1 using the mechanical lift, however, NA #2 denied that she assisted with the transfer. The ADON indicated two staff members should assist with mechanical lift transfers to ensure resident safety An interview conducted with the Administrator on 9/17/25 at 2:30 PM revealed two staff members should assist with all mechanical lift transfers to ensure the resident was safe.