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	08/21/2025

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 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** 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 [DATE] 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 [DATE] 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 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.

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. - 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 [DATE] 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 at 0 units for at least 6 seconds.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 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.