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	07/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to maintain a resident's dignity when Nurse Aide (NA) #1 and NA #2 transferred Resident #67 in a mechanical lift out of her room into the common area hallway to a shower bed on the other side of the hallway with the front of her nude body covered with a bath sheet, exposing her bare hips and the bare sides of her buttocks for 1 of 2 sampled residents reviewed for dignity. Resident #67 stated the NAs would cover the front part of her body with a sheet and would leave her sides exposed, but she really didn't like that. Findings included:Resident #67 was readmitted to the facility on [DATE] with diagnoses which included hemiplegia (complete or partial paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction affecting right dominant side and vascular dementia. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #67 was assessed as having clear speech, was able to express ideas and was able to understand others. The quarterly MDS indicated she was severely cognitively impaired. The assessment indicated Resident #67 required the use of a wheelchair for mobility, was dependent on staff for transfers, dressing and bathing and no limitations upper body or lower body range of motion. The MDS further revealed Resident #67 was coded for rejection of care, but no other behaviors. A review of Resident #67's care plan, last revised 6/27/26, revealed a focus area for Activities of Daily Living (ADLs) due to impaired mobility, chronic pain, morbid obesity, hemiplegia and hemiparesis, and general weakness. Resident #67 required the use of a mechanical lift with two staff members for all transfers. An intervention included assistance with positioning, transfers toileting, personal hygiene, and bathing as necessary or as requested. Resident #67 had an additional focus area relating to behavioral symptoms to include becoming agitated, inappropriate behaviors such as undressing with the door open, refusing care, and crying and cursing. Interventions included reassuring and providing emotional support to Resident #67, providing appropriate level of privacy as indicated, and redirecting her during periods of inappropriate behaviors. During a continuous observation on 7/21/26 at 10:10AM until 10:15 PM in the 200 Hall, NA#1 and NA #2 were observed transferring Resident #67 in a mechanical lift out of her room into the common area hallway to a reclining shower bed on the other side of the hallway (approximately eight feet from Resident #67's room door, across the hall to the other side of the hallway) with the front of her nude body covered with a bath sheet, exposing her bare hips and the bare sides of her buttocks. Other staff members and residents were observed in the hallway during Resident #67's transfer into the reclining shower bed. During an interview with Resident #67 on 7/23/26 at 11:06 AM she revealed the NAs would assist her into the mechanical lift and pushed her in the lift out of the room to the reclining shower bed in the hallway. She explained the NAs would cover the front part of her body with a sheet and would leave her sides exposed, but she really didn't like that and did not know getting a shower could be done differently. An interview with NA #1 on 7/23/26 at 11:40 AM revealed she was on the shower team on first shift, and she and NA #2 had given Resident #67 a shower on 7/21/26. She explained there was not enough room to get the reclining shower bed in Resident #67's room along with the mechanical lift. NA #1 stated she typically left the (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reclining shower bed in the hallway directly in front of Resident #67's door. She stated on 7/21/26, someone must have moved the bed to the other side of the hall across from Resident #67's room and they typically would not push the mechanical lift across the hall. NA #1 stated it was not normal for them to place the reclining bed across the hallway. She was not aware Resident #67 was not completely covered with the bath sheet during the transfer. An interview with NA #2 occurred on 7/23/26 at 1:23 PM. She stated she and NA #1 usually put the reclining shower bed right outside Resident #67's room door as there was no room to put the mechanical lift and reclining shower bed in the room. NA #2 explained that someone must have moved the bed out of the way and put it across the hall from Resident #67's room. NA #2 stated her normal process was to get Resident #67 undressed in her bed as Resident #67 usually wore a shirt that she (NA #2) would have to take off over Resident #67's head and then NA #2 would cover her with a shower sheet to transfer Resident #67 in the mechanical lift. NA #2 indicated she typically made sure Resident #67 was covered up before transferring her and did not realize Resident #67 was exposed on 7/21/26. An observation on 7/23/26 at 2:00 PM of Resident #67's room with the Director of Nursing (DON) and NA #2 revealed the mechanical lift was able to fit in between the two beds in the room, but the reclining shower bed barely fit at the footboard of Resident #67's bed. There was not enough room for the side rail of the reclining shower bed to be lowered. It was determined by the DON the reclining shower bed could not safely be utilized to transfer Resident #67 inside her room due to space constraints. An interview with the DON on 7/23/26 at 2:30 PM revealed she knew having the reclining shower bed and the mechanical lift would be a tight fit in the room. She had the expectation staff would place the reclining shower bed right outside Resident #67's door in the hallway and that she would be transferred by the mechanical lift to the reclining shower bed. The DON stated she would expect nursing staff to preserve Resident #67's dignity by completely covering her during these transfers to the reclining shower bed. An interview with the Administrator on 7/23/26 at 2:53 PM revealed she expected staff to ask Resident #67 about her shower preference and to be transferred with dignity.