STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion Health Center at Brightmore	10011 Providence Road West Charlotte, NC 28277

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a resident had an indication and a diagnosis for the use of an antipsychotic medication. This was for 1 of 5 residents for chemical restraints (Resident #49). The findings included: Resident #49 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (a medical emergency where blood flow to a part of the brain is interrupted, causing brain tissue damage due to lack of oxygen and nutrients), hemiplegia and hemiparesis of the left arm and leg (inability to move/use the left arm and leg), aphasia (a disorder that limits the ability to communicate) following cerebral infarction, benign neoplasm of cerebral meninges (a slow-growing tumor that originates surrounding the brain and spinal cord), adult failure to thrive, and vascular dementia/unspecified severity/with mood disturbance and anxiety. Resident #49's Physician orders included: -Seroquel 25 milligrams (MG) (Quetiapine Fumarate) dated 9/11/24 to give via gastric tube. - Seroquel tablet 25 milligrams (MG) (Quetiapine Fumarate) dated 4/3/25, to give via gastric tube. Resident #49's care plan was revised on 4/3/25 included that she received antipsychotic medication related to her diagnosis of dementia with behavioral disturbances with risk for adverse side effects. The interventions for taking an antipsychotic included consulting a pharmacist to review my psychotropic medications quarterly and as needed for possible changes or reductions. The care plan also included discussing possible side effects of medication with me and my responsible party (RP). A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #49 rarely made herself understood and had severely impaired cognitive skills for daily decision making. She was not coded for potential indicators of psychosis. Resident #49 was coded for diagnosis that included Alzheimer's Disease, cerebrovascular accident/stroke and Non-Alzheimer's Dementia. Resident #49 was coded as currently taking an antipsychotic (high risk medication) on a routine basis and an indication for use was noted. She was coded with impaired extremities on one side and needing functional assistance for less than half of each care activity. Resident #49 had contractures of the left extremities and was unable to use the right extremities. (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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/23/25 at 10:12 AM, Resident #49 was observed asleep in bed and did not respond to verbal stimuli. Observations on 6/24/25 at 11:00 AM and 1:18 PM were completed. The resident was asleep sitting in a chair. She did not awake with her name or voice commands. Observed Resident #49 on 6/25/25 at 9:00 AM while Nurse Aide (NA) #1 provided a bed bath. The resident did not have control of her body and began to lean to the right side. NA #1 had to ask for assistance to complete Resident #49's bed bath. The pharmacy recommendation dated 5/2/25 addressed Seroquel tablet 25 milligrams (MG) order dated 4/3/25 stated that Resident #49 was receiving antipsychotic agent Quetiapine 25 daily but lacks an allowable diagnosis to support its use. The pharmacy recommendation stated the Seroquel 4/3/25 order stated Seroquel use was for squirming. The pharmacist recommended the following diagnosis: Schizophrenia, Delusional disorder, Mood Disorder, Psychosis in the absence of dementia, Tourette's disorder, Hiccups (not induced by other medications), Nausea and vomiting associated with cancer and chemotherapy, Behavioral or psychological symptoms of dementia and Medical illness/delirium with psychotic symptoms. The provider selected the agree with pharmacist indication box. The recommendation form was signed by provider on 5/6/25 with hiccups and nausea associated with cancer circled. Resident #49's Seroquel (Quetiapine Fumarate) orders included: - Seroquel tablet 25 milligrams (MG) dated 6/7/25 included, to give 1 tablet via gastric tube one time a day for nausea and vomiting, hiccups. - Seroquel tablet 25 milligrams (MG) dated 6/13/25 to give Seroquel tablet 25 milligrams (MG) 1 tablet via percutaneous endoscopic gastrostomy (PEG) tube one time a day for dementia with behavioral disturbance. An interview on 6/25/25 at 11:38 AM with Nurse Aide (NA) #1 revealed she had not observed Resident #49 speak or have any movement of her extremities. She stated that she had observed Resident #49 grind her teeth and had not observed hiccups. The NA could not confirm that Resident #49 exhibited behavioral disturbances. The Unit Manager stated on 6/25/25 at 8:37 AM that she had not observed Resident #49 move her extremities. The Unit Manager reported she had observed Resident #49 grind her teeth and had not observed Resident #49 with hiccups. The Unit Manager stated she had not observed Resident #49 exhibit behaviors such as yelling, hitting or pulling PEG-tube. The Unit Manager could not confirm that Resident #49 exhibited behavioral disturbances. Phone interview with Nurse Consultant on 7/3/25 at 4:43 PM revealed that Resident #49 original Seroquel order was dated 9/11/24. The Nurse Consultant stated that Seroquel was reordered every time Resident #49 was readmitted to the facility. She stated that the admitting nurse would select the medications in the electronic medical record (EMR) and the providers would review and make changes as needed.

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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** 2. Resident #92 was admitted to the facility on [DATE]. A review of a social service progress note dated 05/07/2025 at 10:11 AM stated Resident #92 had a planned discharge to an assisted living facility. A review of the discharge MDS assessment dated [DATE] revealed that the discharge status had been coded as discharge to hospital. An interview on 06/25/2025 at 11:15 AM with the MDS Coordinator indicated she received a resident's discharge information through progress notes, discussions with the Social Worker or weekly utilization review meetings. The interview revealed she was newer to the role of MDS Coordinator and had just coded Resident #92 went to the hospital by mistake. She stated it should have reflected the resident was discharged to an assisted living facility. An interview on 06/25/2025 at 3:41 PM with the Director of Nursing (DON) indicated the MDS should be coded accurately. She was not sure why Resident #92's discharge MDS had been coded incorrectly. An interview conducted with the Administrator on 6/26/25 at 11:39 AM revealed the resident MDS assessments should be coded accurately. Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of hospice (Resident #345), discharge status (Resident #92), and oxygen use and functional abilities (Resident #49). This deficient practice occurred for 3 of 21 residents reviewed for accuracy of assessments. The findings included: 1. A review of Resident #345's medical record indicated she was admitted to hospice services on 5/29/25. Resident #345 was admitted to the facility on [DATE]. The admission MDS assessment dated [DATE] revealed Resident #345 was not coded for receiving hospice services. During an interview with MDS Coordinator #1 on 6/26/25 at 10:56 AM she revealed Resident #345 was receiving hospice services prior to being admitted to the facility. MDS Coordinator #1 stated Resident #345 was not coded for receiving hospice services on the admission MDS due to an oversight on her part. An interview with the Director of Nursing on 6/26/25 at 11:37 AM indicated Resident #345 was receiving hospice services and the MDS assessment should have been coded accurately. An interview conducted with the Administrator on 6/26/25 at 11:39 AM revealed the resident MDS assessments should be coded accurately. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #49 was originally admitted to the facility on [DATE] with diagnoses that included cerebral vascular accident (CVA), hemiplegia, left hip contracture, and dependence on supplemental oxygen. Resident #49 physician orders dated 6/7/25 included to administer oxygen at 2 liters continuously via nasal cannula at bedtime for oxygen supplement for hypoxia at bedtime. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #49 rarely made herself understood and had severely impaired cognitive skills for daily decision making. She was coded as needing functional assistance for less than half of each care activity. The MDS assessment was not coded for oxygen use. Resident #49 was observed with oxygen at 2 liters via nasal cannula on 6/24/25 at 8:15 AM and 6/25/25 at 8:40 AM. An interview on 6/25/25 at 11:38 with Nurse Aide (NA) #1 revealed that she had never observed Resident #49 move on her own or assist with any of her care. NA #1 stated that Resident #49 was dependent in all care areas and required at least 2 people to provide total care. NA #1 reported that Resident #49 used oxygen when in bed sleeping. An interview on 6/25/25 at 9:10 AM with the Unit Manager revealed that Resident #49 was total care and dependent in all areas of activities for daily living (ADLs) and required oxygen at bedtime. The MDS Coordinator was interviewed on 6/25/25 at 4:01 PM. The MDS Coordinator stated she collected resident status information from medical records and clinical staff in the daily team meetings which she used to code the MDS assessment. The MDS Coordinator confirmed that Resident #49 used oxygen. She stated Resident #49's oxygen usage was coded in error and the functional status for Resident #49 was coded incorrectly. The Administrator was interviewed on 6/26/25 at10:42 AM. The Administrator stated the MDS Coordinator should collect information regarding a resident from therapy and clinical nursing, and orders should be reviewed for MDS coding. The Administrator reported she would have expected the coding to accurately represent the resident and orders for treatment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop personalized comprehensive care plans in the areas of oxygen therapy (Resident #16) and include accurate interventions in a care plan (Resident #41) for 2 of 21 residents reviewed for comprehensive care plans. The findings included: 1. Resident #16 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, pneumonia, and dependence on supplemental oxygen. A review of the admission Minimum Data Set (MDS) dated [DATE] showed Resident #16 was coded for oxygen therapy. A review of Resident #16's medical record revealed a current physician order dated 6/13/25 for two liters of continuous oxygen via nasal cannula. A review of Resident #16's June 2025 Medication Administration Record (MAR), for the period of 6/1/25 through 6/30/25, revealed she had been receiving the oxygen as ordered. An observation on 6/23/25 at 2:44 PM revealed Resident #16 in her room receiving oxygen via nasal cannula from concentrator. A review of Resident #16's care plan as of 5/30/25 revealed there was no care area in place for continuous oxygen use. An interview with MDS Coordinator #1 on 6/25/25 at 3:54 PM revealed the information in each care plan was gathered in their interdisciplinary meetings and from nurse and clinical notes and nurse aide charting. The MDS nurses complete each resident care plan. MDS Coordinator #1 stated Resident #16 used continuous oxygen since she was admitted , and it was an oversight oxygen use was not included in her care plan. An interview with the Director of Nursing (DON) on 6/26/25 at 11:39 AM revealed the MDS Coordinators were tasked with completing the comprehensive care plans. He had the expectation Resident #16's care plan would include oxygen therapy. An interview with the Administrator on 6/26/25 at 11:43 AM revealed she had the expectation all care plans should be updated. 2. Resident #41 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia, diabetes and epilepsy. A review of Resident #41's medical record revealed a current physician order dated 6/2/25 for wearing an abdominal binder for protection due to pulling at feeding tube. May remove for care and replace when finished. Assess skin integrity every shift. There were no other current or discontinued orders for hand mitts for Resident #41 in his medical record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission Minimum Data Set (MDS) dated [DATE] showed Resident #41 was not coded for restraints. A review of Resident #41's June 2025 Medication Administration Record (MAR), for the period of 6/1/25 through 6/30/25, revealed the abdominal binder was in place each shift. Resident #41's current care plan dated 6/23/25 revealed there was a care problem area use of bilateral mitts to hands and abdominal binder due to pulling at feeding tube with increased risk for associated complication and injuries. Interventions included administering abdominal binder as ordered and monitor and document for side effects and effectiveness, ensuring there is a physician's order for device, and ensuring correct positioning with proper body alignment while using device. An interview was completed with Nurse #2 on 6/25/25 at 2:20 PM and revealed Resident #41 never used bilateral mitts on his hands. She stated the abdominal binder was in place to keep him from pulling at his feeding tube. An interview with MDS Coordinator #1 on 6/25/25 at 3:57 PM revealed Resident #41 never used hand mitts, just the abdominal binder and the hand mitts were included in the care plan by mistake. An interview with the DON on 6/26/25 at 11:43 AM revealed the Unit Managers complete the baseline care plans when residents were admitted and the MDS Coordinators were tasked with completing the comprehensive care plans. He noted when Resident #41 came to the facility he was in and out of the hospital and he kept taking out his feeding tube. The hand mitts were never used, and the abdominal binder had been sufficient. An interview with the Administrator on 6/26/25 at 11:45 AM revealed she had the expectation the hand mitts would be taken off the care plan for Resident #41.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to develop a comprehensive care plan within 7 days of completing a comprehensive assessment for 1 of 21 residents (Resident #56) reviewed for care plans. The findings included: Resident #56 was admitted to the facility on [DATE] with diagnoses that included fracture of the left humerus (upper arm bone), falls, and urinary tract infection. The admission minimum data set (MDS) assessment dated [DATE] indicated Resident #56 had upper extremity impairment to one side, required partial to moderate assistance with activities of daily living (ADL), was frequently incontinent of bowel and bladder, was at risk for developing pressure ulcers and coded for falls. The MDS assessment was signed on 6/17/25 verifying it was completed. Resident #56's Care Area Assessment (CAA) Summary dated 6/10/25 revealed the triggered care areas included ADL functional/rehabilitation potential, urinary incontinence, falls, pressure ulcers and nutritional status. The care plan decision completion date for all the care areas was 6/11/25. A review of Resident #56's medical record revealed the care plan dated 6/05/25 included focus areas and interventions related to discharge planning, mood disorder and activities. The care plan did not include focus areas or interventions related to the triggered care areas on the CAA related to ADL function, falls, urinary incontinence, pressure ulcers and nutrition. An interview conducted with MDS Coordinator #1 on 6/26/25 at 11:02 AM MDS Coordinator #1 stated the day after admission, or if on a weekend, the following Monday she developed and completed the resident's comprehensive care plan. She revealed the comprehensive care plan was revised after the admission MDS was completed to include any additional care areas triggered on the CAA. MDS Coordinator #1 indicated Resident #56 was admitted to the facility due to a fall with a fracture, was incontinent and requiring assistance with ADL and her admission MDS assessment was completed on 6/10/25. MDS Coordinator #1 revealed she was unaware that Resident #56's comprehensive care plan had not been completed and it was an oversight on her part. During an interview with the Administrator on 6/26/25 at 11:40 AM she stated the MDS Coordinators were responsible for developing and completing the residents' comprehensive care plans and a comprehensive care plan should have been completed for Resident #56.

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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** Based on observations, record reviews, and staff interviews, the facility failed to use sterile gloves and failed to perform hand hygiene while providing tracheostomy care to Resident #62. This deficient practice occurred for 1 of 1 resident observed for tracheostomy care (Resident #62). The findings included: Resident #62 was originally admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia and tracheostomy. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #62 was coded for tracheostomy and tracheostomy care. The care plan dated 2/7/24 included Resident #62 had a tracheostomy with risk for complications including decreased oxygenation, infection, nutritional imbalance, anxiety, and decreased ability to communicate. The interventions included providing trach care as ordered and observing tracheostomy site for redness, drainage, signs of infection each shift and report to nurse or provider. Resident #62's physician orders included: - Change the disposable inner cannula every shift and as needed every shift. (8/15/24) - Respiratory therapist to change tracheostomy tube every month. (8/15/24) Nurse #1 was observed on 6/25/25 at 10:49 AM performing trach care for Resident #62. Nurse #1 set up a table with a white paper barrier on top of table. Next, Nurse #1 placed tracheostomy care supplies on the barrier which included: one trach drainage gauze, one trach inner cannula, and six pairs of gloves. She did not use a tracheostomy kit. Nurse #1 donned a clean gown and 2 pairs of non-sterile clean gloves. She then removed the dirty dressing and placed the dirty dressing in the trash. Nurse #1 doffed her gloves and without sanitizing her hands, donned 2 pairs of non-sterile gloves and applied a clean gauze to Resident #62's trach site. Using the same gloves, Nurse #1 removed the trach inner cannula and disposed of the inner cannula in the trash. Nurse #1 removed her gloves, then donned a new pair of non-sterile gloves without sanitizing her hands and inserted a new inner cannula in Resident #62's trach site. Nurse #1 doffed her gloves and gown and washed her hands at the sink in Resident #62's room. An interview conducted on 6/25/25 at 2:10 PM with Nurse #1 revealed she was aware that she had not sanitized her hands each time she had doffed her gloves. She stated she should have had hand sanitizer with her supplies or should have washed her hands at the sink before donning a new pair of gloves. Nurse #1 stated that a respiratory therapist used sterile trach kits when providing trach care. She was not aware that she needed sterile gloves for trach care. (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 conducted on 6/25/25 at 2:43 PM with the Infection Preventionist/ Assistant Director of Nursing (ADON) revealed her expectation was that every nurse would sanitize their hands every time that they removed their gloves and before putting on clean gloves during wound and trach care. The ADON further stated staff received education on infection control annually and multiple times during the year. An interview on 6/26/25 at 12:23 AM with the Director of Nursing (DON) revealed he was not aware of Nurse #1's errors during trach care. The DON stated it was his expectation that Nurse #1 followed the best practices infection control to avoid introducing microorganisms into the trach site. The DON stated that the respiratory therapist visited Resident #62 to complete sterile trach care the previous day.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 5 medication errors out of 27 opportunities, resulting in a medication error rate of 18.52% for 1 of 4 residents (Resident #49) observed during the medication administration observation. The findings included: Resident #49 was originally admitted to the facility on [DATE]. Her diagnosis included presence of a percutaneous endoscopic gastrostomy (PEG) tube. A PEG-tube is a feeding tube inserted through the skin and the stomach wall to provide nutrition and a route for medication administration. A review of Resident #49's active physician orders included an order dated 6/7/25: -Enteral Feed Order every shift flush with 30ml (milliliters) of water then administer each medication separately. Dissolve each medication in 10-15 ml of water and flush with 5 ml water after each medication. Flush with 30ml water as final flush. On 6/25/25 at 8:37 AM, the Unit Manager was observed as she began to prepare medications for administration to Resident #49 via PEG-tube. The medications included: 81mg (milligrams) aspirin (used for stroke prevention)- 1 tablet, 25 mg metoprolol (used blood pressure management) - 1 tablet, 25mg Seroquel (used for hiccups) -1 tab, and 4 mg silodosin (used relax urethra to prevent urine retention)- 1 capsule. All four medications were placed in a 30 ml medication cup. The Unit Manager poured the medication tablets in a clear plastic sleeved and crushed the medication. Next, she opened the medication capsule and emptied the medication in the mix of crushed medications. Then the Unit Manager poured 5mg/ml of Metoclopramide (used for nausea) into a medication cup for a total of 10 ml. Next, she poured 30 ml of ProStat (protein supplement) into a medication cup. The Unit Manager was observed on 6/25/25 at 8:48 AM as she [NAME] the medications for administration into Resident #49's room. After the nurse connected a syringe to the resident's PEG- tube, she flushed the tube with 30 ml of water. The crushed medications were mixed with 60 ml of water in a cup and the solution was poured into the syringe connected to Resident #49's PEG-tube. The Unit Manager then combined the Metoclopramide and Prostate with 20 ml of water for a total of 60 ml of solution. She then administered the solution into the syringe and then the PEG-tube. The Unit Manager completed the medication administration by flushing the resident PEG-tube with 60 ml of water. An interview was conducted with the Unit Manager on 6/25/25 at 2:11 PM. The Unit Manager reported she was nervous and did not routinely work with Resident #49. The Nurse Manager stated that her normal practice was to combine all medications and administer in the PEG- tube at once as a cocktail. The Unit Manager stated that she had not reviewed the medication administration order for Resident #49 prior to administering the medications. An interview was conducted on 6/26/25 at 10:29 AM with the facility's Director of Nursing (DON). During the interview, the DON stated he would expect that orders are followed for all medications administered to a resident.