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 ______	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 09/26/22 through 09/29/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1SX911.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 09/26/21 through 09/29/22. 14 of the 31 complaint allegations were substantiated resulting in deficiencies. Intakes, NC00192166, NC00191711, NC00190791, NC00190238, NC00190124 NC00189352, NC00188480	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		10/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/21/2022

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.

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide care in a manner to maintain the resident's dignity by not providing incontinence care when requested. This resulted in Resident #37 crying while waiting for incontinence care and she reported it made her feel worthless, horrible, bad and "didn't deserve to be treated that way". This was evident for 1 of 6 residents who were reviewed for dignity and respect (Resident #37). Findings included: Resident #37 was admitted to the facility on 08/08/22. A review of the admission Minimum Data Set (MDS) dated 08/15/22 revealed that Resident #37	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 Resident Rights/Exercise of Rights Corrective Action for Affected Residents For resident # 37, a corrective action was obtained on 9/26/2022. NA#1provided incontinent care to resident #37. On	

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F 550	Continued From page 2 was cognitively intact. Resident #37 needed extensive assisted with all activities of daily living with the exception of eating. While touring the 100 hall on 09/26/22 at 11:00 am Resident #37 was observed to call out for assistance and the call light was activated, upon entering Resident's room, the room had a noticeable odor of urine. Resident #37 indicated she was wet and had not been changed since the night shift. Resident #37 indicated that she had informed Nursing Assistant (NA) #1 that she needed to be changed when she came in to deliver the breakfast meal between 8:30 am and 8:45 am. Resident #37 indicated that NA #1 told her she would be back, and she never returned. Resident #37 voiced she had to eat her breakfast while she was "soaked" and wet and it was not a good feeling. While in the room it was observed Resident #37's breakfast was still in front of her during this tour at 11:15 am. Resident #37 indicated that she had been waiting for assistance for over 3 to 4 hours. Resident #37 stated that this made her feel horrible, worthless, and bad. Resident #37 knew what time it was because she had called her daughter her family for help. During an observation at 11:37 am on 09/26/22, it was observed Resident #37 was double briefed and both briefs were saturated with urine. During care Resident #37 started to cry and stated, "I know I'm fat and I'm hard to move but I don't deserve to be treated this way". NA #1 indicated she was working in the kitchen from 7:00 am until she passed the trays on the hall around 8:45 am, and she had not provided care for Resident #37 since she got to work at 7:00 am. NA #1 stated that this was because the kitchen needed help.	F 550	9/26/2022, NA#1 was re-educated immediately by the Director of Nursing, on the resident's right to dignity, respect and providing incontinent care according to resident's plan of care. On 9/26/2022, Nurse Manager monitored hall during lunch and dinner to ensure call light being answered during meals and incontinent care being provided as indicated. Corrective Action for Potentially Affected Residents All residents who need assistance with toileting have the potential to be affected by this alleged deficient practice. On 10/12/2022, the Director of Nursing reviewed all current resident medical record to identify residents that needed assistance with toileting. On 10/12/22, 10/13/2022, and 10/15/2022 the Director of Nursing and Nurse Managers performed audits for incontinent episodes during meals. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned certified nurse aide (CNA). Systemic Changes On 10/5/2022, the Director of Nursing began in-servicing all current full time, part time and PRN Registered Nurse (RN), Licensed Practical Nurse (LPN) and CNA's and agency RN, LPN and CNA. This in-service included the following topics: • Residents Rights • Toileting before, during, and after meal times The Director of Nursing will ensure that any Licensed Nurse(RN, LPN) or CNA who has not received this training by	

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F 550	Continued From page 3 A phone interview was attempted on 09/27/22 at 10:00 am with NA #11 who worked with Resident #37 on the third shift that began on 09/25/22 and ended on 09/26/22. An interview was conducted with the Director of Nursing on 09/28/22 at 7:47 am, and he indicated the Nursing Department was staffing challenged and he had knowledge of staff doing double work at the facility. The DON indicated his expectation was for all residents in the facility to be treated with dignity and respect and no resident should have to wait over 30 minutes for care and treatment. An interview was conducted with the Administrator on 09/29/22 at 3:15pm. She indicated that her expectation was for staff to always treat residents with respect and dignity.	F 550	10/17/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and nurse aides who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance Beginning 10/24/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Residents Rights. The monitoring will include reviewing a sample of 5 residents prior to and during meal time for toileting and incontinent care needs. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 10/17/2022	

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F 641	Continued From page 4	F 641		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for 1 of 19 MDS assessments reviewed (Resident #64). Findings included: Resident #64 was readmitted to the facility 12/30/2021 with diagnoses to include heart failure and Parkinson's disease. The quarterly MDS dated 8/27/2022 it was documented Resident #64 had limited range of motion of one side of her lower extremities. Resident #64 was observed on 9/29/2022 at 10:00 AM standing beside her wheelchair. Resident #64 was not holding onto anything and was standing independently. An interview was conducted with the Director of Rehabilitation on 9/28/2022 at 10:19 AM. The Director of Rehabilitation reported Resident #64 had stretching exercises to her lower extremities, but she did not have limited range of motion. Physical Therapist #1 (PT) was interviewed on 9/28/2022 at 10:42 AM. PT #1 reported he had provided care to Resident #64 several times, and she did not have limited range of motion of either lower extremity.	F 641	F641 Accuracy of Assessments For resident # 64 a corrective action was obtained on 9/29/22 by modifying and correcting the Minimum Data Set MDS) assessment for assessment reference date (ARD) of 08/27/22. Coding of question G0400B (Functional Limitation in Range of Motion) was corrected to accurately reflect that resident did not have limitation in one lower limb that was not present during the specified lookback timeframe. Correction was completed by the facility Minimum Date Set Nurse on 9/29/2022. Corrected Minimum Data Set (MDS) assessment was re-submitted to the state and accepted into the data base on 9/30/2022. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit of all current residents who have had a Minimum Data Set (MDS) assessment completed during the past three months was completed in order to identify coding error in section G0400B Functional Limitations of Lower Extremity(s). This audit was conducted by the Clinical Reimbursement Consultant on 10/14/2022.	10/17/22

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F 641

Continued From page 5

An interview was conducted with PT #2 on 9/28/2022 at 10:56 AM. PT #2 reported she had provided rehabilitation services to Resident #64 several times and she did not have any joint limitation, contracture, or impairment in her lower extremities.

Resident #64 was interviewed on 9/29/2022 at 10:13 AM. Resident #64 reported she had received therapy in the past to help with strengthening. Resident #64 demonstrated full range of motion of her lower extremities and reported she had no impairment of her lower legs. Resident #64 lifted each leg and demonstrated full range of motion of her ankles, knees, and hips and then kicked her legs out in front of her. Resident #64 stated, "I don't have any problems with my legs." Resident #64 concluded by reporting she was able to take a few steps without assistance but required the wheelchair when she needed to go longer distances.

The MDS nurse was interviewed on 9/29/2022 at 2:08 PM. The MDS nurse reported she was not certain why limited range of motion of one side of lower extremities was documented for Resident #64. The MDS nurse reported it may have been an error.

The Administrator was interviewed on 9/29/2022 at 5:19 PM. The Administrator reported that she expected MDS assessments to be coded accurately.

F 641

Audit Results:
22 Minimum Data Set records were reviewed with the Assessment Reference Dates (ARD) within the last 90 days with dates between 6/30/2022 and 9/29/2022.
" One (1) resident was identified out of the 22 records reviewed as being coded inaccurately in section G0400B Functional Limitations of Lower Extremity (s) for the Minimum Data Set (MDS) assessments reviewed. The identified resident had a modification completed of their Minimum Data Set (MDS) to reflect the correct coding in section G0400B Functional Limitations of Lower Extremity on 10/15/2022 with submission to the state on 10/17/2022.
Systemic Changes

On 10/17/22, the Clinical Reimbursement Consultant completed an in-service training for the facility Minimum Data Set (MDS) nurse(s) that included the importance of thoroughly reviewing the medical record, interviewing staff and observing each resident during the assessment window before coding the Minimum Data Set (MDS) assessment. Special emphasis was highlighted on:

" The importance of thorough review of the medical record including progress notes, nurse aide documentation, nursing notes, therapy interviews and observing each resident during the seven day lookback for completion of Minimum Data Set (MDS) Assessment. This information is located in the Resident Assessment Instrument (RAI) manual in chapter 3

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F 641	Continued From page 6	F 641	pages G-36 through G-39 and has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Beginning 10/24/2022, The Director of Nursing or designee will review Minimum Data Set Assessments (Quarterly, Admission, Annual or Significant Change) for 5 residents for accuracy of coding of MDS items utilizing the Accurate Coding of MDS Audit Tool. This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 10/17/2022	
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		10/17/22

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F 677	Continued From page 7 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide incontinence care when requested for 1 of 6 residents (Resident #37) reviewed for activities of daily living (ADL). Findings included: Resident #37 was admitted to the facility on 08/08/22. A review of the admission Minimum Data Set (MDS) dated 08/15/22 revealed that Resident #37 was cognitively intact. Resident #37 needed extensive assisted with all activities of daily living with the exception of eating. No issues of refusals of care noted. A review of an ADL care plan dated 09/02/22 revealed Resident #37 required assistance with ADL care and was incontinent of bowel and bladder. Interventions included instructions to check on her frequently and provide incontinence care as needed. An observation on 09/26/22 at 11:00 am revealed Resident #37's call light was activated. On 09/26/22 at 11:15 am, Resident #37 was observed call out verbally for staff's assistance and the call light was activated. Resident #37's room had a noticeable odor of urine. Resident #37 indicated she was wet and had not been	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-677 ADL Care Provided for Dependent Residents Corrective Action for Affected Residents For resident# 37 incontinent care provided by Certified Nurse Aide (CNA) on 9/26/2022 Nurse Manager monitored hall during lunch and dinner to ensure call light being answered during meals and incontinent care being provided as needed. Corrective Action for Potentially Affected Residents All residents who need assistance with toileting have the potential to be affected by this alleged deficient practice. On 10/12/2022 the Director of Nursing reviewed all current resident medical records to identify residents that needed	

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F 677	Continued From page 8 changed since the night shift. Resident #37 indicated that she had informed Nursing Assistant (NA) #1 that she needed to be changed when she came in to deliver the breakfast meal between 8:30 am and 8:45 am. Resident #37 indicated that NA #1 told her she would be back, turned her call light off, and never returned. Resident #37 voiced she had to eat her breakfast while she was "soaked" and wet and it was not a good feeling. While in the room it was observed Resident #37's breakfast was still in front of her during at 11:15 am. Resident #37 indicated that she had been waiting for assistance for over 3 to 4 hours. Resident #37 stated that this made her feel horrible, worthless, and bad. Resident #37 indicated she knew what time it was because she used her phone call to call her daughter for help. During an observation at 11:37 am on 09/26/22 care was provided to Resident #37 by NA #1. It was observed Resident #37 was double briefed and both briefs were saturated with urine. During care Resident #37 started to cry and stated, "I know I'm fat and I'm hard to move but I don't deserve to be treated this way". NA #1 indicated she was working in the kitchen from 7:00 am until she passed the trays on the hall around 8:45 am, and she had not provided care for Resident #37 since she got to work at 7:00 am. NA #1 also indicated that she turned the call light off at 8:45 am. NA #1 stated this was because the kitchen needed help. During an interview with Nurse #1 on 09/27/22 at 9:00 am she revealed she had no knowledge of Resident #37 not receiving care on 09/26/22 until 11:30 am. Nurse #1 also indicated that sometimes the NAs had to work in the kitchen during the morning and they tried to cover the hall	F 677	assistance with toileting. On 10/12/2022, 10/13/2021, and 10/15/2022 for the breakfast, lunch, and dinner meal the Nurse Managers audited all current residents for toileting and incontinent care needs prior to meal delivery and during meal time. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned CNA. Systemic Changes On 10/05/2021 the Director of Nursing began in-servicing all current full time, part time, and agency Licensed Nurses (RN, LPN) and CNA's. This in-service included the following topics: • ADL Care, Call Lights, and Care Need Requirements • Toileting before, during, and after meal times The Director of Nursing will ensure that any Licensed Nurses or CNA who has not received this training by 10/17/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in- service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Licensed Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.	

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F 677	Continued From page 9 to meet the needs of the residents. A phone interview was attempted on 09/27/22 at 10:00 am with NA #11 who worked with Resident #37 on the third shift that began on 09/25/22 and ended on 09/26/22. An interview was conducted with the Director of Nursing (DON) on 09/28/22 at 7:47 am, and he indicated the Nursing Department was staffing challenged and he had knowledge of staff doing double work at the facility. The DON indicated that all resident's incontinence care needed to be done during the morning round when first shift staff came on duty. The DON indicated his expectation was for all residents in the facility to be assisted with incontinence care every 2 hours and whenever needed. He also indicated no residents in the facility should wait over 15 to 20 minutes for care to be provided. The DON indicated he was not aware a resident had to wait 3 to 4 hours for incontinence care to be provided. An interview was conducted with the Administrator on 09/29/22 at 3:15 pm. She indicated that her expectation was for staff to provide care and treatment for all residents in a timely manner. The Administrator stated residents should not have to wait for hours at a time to have care provided.	F 677	Quality Assurance Beginning 10/24/2022, The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring ADL care. The monitoring will include reviewing a sample of 5 residents prior to and during meal times for toileting and incontinent care needs. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality. Reports will be given by the Director of Nursing to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 10/17/2022	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		10/17/22

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F 686	Continued From page 10 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, family, Nurse Practitioner (NP) and Wound MD interviews, the facility failed to provide the necessary care and services to prevent/treat pressure ulcers. The facility also failed to apply a wound dressing as ordered by the physician for 1of 5 residents reviewed for pressure ulcers (Resident #26). The findings included: Resident #26 was admitted on 7/25/22 with diagnoses that included contusion and laceration of right cerebrum without loss of consciousness, traumatic subarachnoid hemorrhage without loss of consciousness. Admission Minimum Data Set (MDS) dated 8/1/22 revealed Resident #26 had moderate cognitive impairment with no behaviors or rejection of care. The resident required extensive assistance with bed mobility, toileting, personal hygiene, was always incontinent of bladder and occasionally incontinent of bowel. The resident had 2 stage 3 pressure ulcers present on admission and was receiving pressure ulcer care. Physician orders for Resident #26 included:	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 Treatment/SVCS to Prevent/Heal Pressure Ulcer Corrective action for resident(s) affected by the alleged deficient practice: On 9/29/2022, Resident #26 skin was assessed by QA Nurse Consultant and the current treatment was completed. On 9/29/2022 resident #26 risk for developing pressure ulcers was reviewed by QA Nurse Consultant and the care plan and services needed to prevent pressure ulcers was updated for appropriate interventions. On 9/27/2022 Reordered condom catheters delivered to facility. On 9/27/2022 Resident #26 Foley	

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Continued From page 11

- Remedy Nutrashield cream to buttocks every shift and as needed for wound healing/prevention. 7/25/22
-Pressure relieving mattress 7/25/22
-Prostat, supplement, one time a day for additional protein/wound healing 30 milliliters (ml) via gastric tube (a tube place directly into the stomach for feeding) mixed with 60ml of water 8/1/22
-Unstageable wound of the right buttock- cleanse area with normal saline/wound cleanser, pat dry, apply hydrocolloid dressing three times per week on every Tuesday Thursday and Saturday. 9/20/22

Resident #26's Care Plan initiated on 7/26/22 revealed:

Resident #26 was incontinent of bladder with increased risk of skin breakdown and infections. The interventions included check the resident frequently throughout shift for incontinence. Wash, rinse, and dry perineum and change clothing as needed after incontinence episodes. Report any open areas, rash or irritation to skin to nurse if noted. The resident used incontinence briefs and needed assistance with all incontinence care.

Resident #26 had a pressure ulcer and was at risk for development of additional pressure ulcers due to decreased ability to re-position, incontinence, and immobility. The interventions included observe the residents dressing each shift to ensure it was intact and adhering. Report loose dressings to the nurse.
Observe/document/report to MD changes in skin status, administer treatments as ordered and monitor for effectiveness. Apply moisture barrier

F 686

catheter placed per MD order related to condom catheters not adhering due to retracted penis.
On 9/29/2022, the QA Nurse Consultant assessed resident #26 skin and completed wound care. No new skin breakdown noted.
Corrective action for residents with the potential to be affected by the deficient practice:
All residents who have current skin breakdown and are at risk for skin breakdown have potential to be affected by the alleged deficient practice. On 10/13/2022, the DON/Unit Managers reviewed all resident with current skin breakdown for appropriate treatment orders and care planned interventions. On 10/13/2022 to 10/14/2022, the Director of Nursing and Unit Managers completed body audits for 100 % of current residents to identify any new skin breakdown and ensure wound care being provided as ordered. No issues noted.
Systemic Changes:
On 10/5/2022, the Director of Nursing began educating all full time, part time, and prn licensed nurses (RN, LPN), medication aides, and certified nursing assistant (CNA) and agency staff on the following topics:
• Wound Prevention
• Wound Care
Any clinical staff RN, LPN, medication aide or CNA for full time, part time, PRN, and agency) who did not receive in-service training by 10/17/2022 will not be allowed to work until training is completed. This information has been

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F 686	Continued From page 12 with each brief change. Resident #26 had an ADL Self Care Performance Deficit related to impaired mobility. The interventions included staff assistance to re-position and turn in bed and report any redness, broken areas or irritation noted on skin to the nurse. Resident #26 had actual impairment to his skin integrity. The interventions included encourage good nutrition and hydration to promote healthier skin. Review of Resident #26's wound notes revealed the following: On 8/9/22 the 2 stage 3 pressure ulcers noted on admission were resolved and barrier cream was recommended. On 8/23/22 a new left buttock non pressure related, moisture associated wound was noted. The treatment plan included hydrocolloid dressing 3 times a week, barrier cream 3 times a day, reposition resident and offload wound. On 8/30/22 the left buttock non pressure related, moisture associated wound was resolved. On 9/20/22 a new right buttock pressure related unstageable deep tissue injury (DTI) with intact skin was noted. The area was 6.5 x 4 centimeters (cm). The treatment plan included hydrocolloid dressing 3 times a week, reposition resident every 1 to 2 hours and offload wound. On 9/27/22 the right buttock pressure related unstageable DTI had deteriorated and the skin	F 686	integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any clinical staff RN, LPN, medication aide or CNA for full time, part time, PRN, and agency) will receive this education during orientation. Quality Assurance: Beginning the week of 10/24/2022, The Director of Nurses or designee will monitor Compliance using the QA Tool for Pressure Ulcer Prevention. Monitoring will include observation of 5 residents to ensure wound care is being completed as ordered. This is to be completed weekly x 4 weeks, then monthly x 2 months. Reports will be presented by the Director of Nursing to the Monthly Quality of Life - QA committee and corrective action initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/17/2022	

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was no longer intact. The area was 7.5 x 3.5 x 0.1cm with light serous exudate. This area was debrided on that date. In addition, there was a new left buttock pressure related unstageable DTI with intact skin and the area was 6 x 3cm. The treatment plan included hydrocolloid dressing 3 times a week, reposition resident every 1 to 2 hours and offload wound.

During an interview on 09/26/22 at 11:05 AM Resident #26's family member stated he had 2 small wounds on his buttocks before he came to the facility, but his bottom looked much worse now. She did not think the facility was doing enough for his wounds. She revealed the facility did not have the proper size condom catheter for the resident. The condom catheters were being used to ensure the resident stayed dry so the wound could heal but the catheters provided by the facility did not fit properly. The condom catheters the facility provided were too big and would either come off easily or would leak. She further revealed because of the leakage she was afraid the wounds would continue to get worse.

An interview with Nurse Aide (NA) #4 on 09/27/22 at 4:32 PM revealed the facility did not have the proper size condom catheters for Resident #26, because they did not have the condom catheters and indwelling catheter was placed on that day. She further revealed when the facility was out of condom catheters supply staff was notified and would reorder.

An observation of the supply room was conducted on 9/27/22 at 4:35 PM with NA#4 revealed there were 3 small boxes of size 36mm (large) condom catheters in the supply room. There were no other sizes observed.

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An observation of Resident #26's wound care was made on 09/28/22 at 11:20 AM. NA# 5 removed the old dressing. Nurse #2 was at the resident's bedside with dressing change supplies ready. He had created a clean area on the resident's bedside table. Nurse #2 performed hand hygiene and donned clean gloves. Resident #26's left and right buttock had large reddened areas. The wounds were close together and created a butterfly shape. In addition to the large, reddened area the left buttock the was a pea sized purple area that was open with a yellow center. The right buttock wound was open and had a small amount of clear drainage. The Nurse #2 cleansed the entire wound with dermal wound cleanser and patted the area dry. Nurse #2 performed hand hygiene and donned clean gloves. He opened the hydrocolloid dressing and cut it to fit the residents wound. The dressing was applied to the wound, a clean brief was put on Resident #26, he was then repositioned and covered.

During an interview with Nurse #3 on 9/29/22at 11:45 AM the NAs would report if the resident had a new or worsening area on their skin. She would then assess and report changes to the Unit Manager and MD. She stated she followed the physician order for dressing changes.

During an interview with NA #6 on 9/29/22 at 12:20 PM she revealed she made rounds on residents every 2 hours. During rounds she would check the incontinent resident and dry them if needed. She stated when Resident #26 had a condom catheter it would leak because it was too big. When staff would check or move him, they had to be very careful because the

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F 686	Continued From page 15 catheter would come off easily. If a resident had a new area of concern or a worsening area, she let the nurse know. She further revealed Resident # 26's wound looked like it was getting worse, sometimes the dressing was soiled and had to be removed. If she had to remove the dressing, she notified the nurse to reapply the dressing. She stated the nurses don't always put the dressing back on. There were times when she would provide incontinence care to the resident and the dressing would not be in place. During an interview with the NP on 09/29/22 at 3:38 PM she revealed she was aware the wounds on Resident #26's buttocks and wound care should be provided as ordered. She further revealed they used condom catheters to keep the resident's skin dry and to assist with wound healing. Resident #26's condom catheter would frequently come off, she had tried to place condom catheters on the resident herself. On 9/27/22 she ordered an indwelling catheter to better keep the wound dry. The NP indicated Resident #26 being wet or soiled will negatively impact the residents wound healing. During a follow up interview on 09/29/22 at 4:17 PM Resident #26's family member revealed staff placed an indwelling catheter on 9/27/22 because there were still no condom catheters his size. She stated she had been asking for a smaller condom catheter for more than a week, but the facility had been out. This was not the first time the facility had ran out of condom catheters that fit Resident #26. The family member stated when she arrived that morning there was a lot of blood in the catheter tubing and the resident complained that it hurt. She asked staff to remove the indwelling catheter. Staff removed	F 686		

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the indwelling catheter and placed a brief on Resident #26 because there were still no condom catheters that fit him.

An interview with the Administrator on 09/29/22 at 4:07 PM she revealed if staff notice supplies were low or out, it should be requested from supply or the DON. She stated the condom catheters should have been ordered and staff should communicate needs.

An observation and interview were made on 09/29/22 at 4:19 PM NA #6 was preparing to perform incontinence care. When the residents brief was removed, there was no hydrocolloid dressing on Resident #26's wound and stool was observed on the wound bed. NA #6 stated she did not know why the dressing wasn't in place and she did not remove it. She stated the nurse was on break and she would notify her about the dressing when she returned

During an interview on 09/29/22 at 4:23 PM this surveyor made the DON and Nurse Consultant aware that Resident#26 did not have the ordered dressing on his wound, NA #6 was at the bedside and needed someone to replace the dressing. The DON stated the resident should have had the dressing in place and wound care orders should be followed. The Nurse Consultant stated she would replace the dressing for Resident #26.

On 09/29/22 at 04:40 PM The Nurse Consultant revealed the nurse was aware Resident #26's dressing was off but had not had time to reapply it. The Nurse Consultant stated she applied Resident #26's dressing.

On 09/29/22 at 4:28 PM an interview was

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F 686	Continued From page 17 conducted with the Wound MD that revealed, Resident #26 had 2 pressure related DTIs. The DTI on the right buttock had deteriorated and required debridement. The DTI on the left buttock was newly acquired. The Wound MD stated he expected wound orders to be completed as ordered. He further stated if the resident was wet or soiled this would facilitate further skin breakdown and possible infection. He revealed that Resident #26 was almost always wet when he came in to provide wound care.	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff	F 692	The statements made on this plan of	10/17/22

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F 692	Continued From page 18 interviews, and Registered Dietician (RD) interview, the facility failed to follow the RD's recommendation to reweigh a resident identified with significant weight loss to determine if the change in weight status was accurate for 1 of 5 residents reviewed for nutrition (Resident #26). The findings included: Resident #26 was admitted on 7/25/22 with diagnoses that included contusion and laceration of right cerebrum without loss of consciousness, traumatic subarachnoid hemorrhage without loss of consciousness. The admission Minimum Data Set (MDS) dated 8/1/22 revealed Resident #26 had moderate cognitive impairment with no behaviors or rejection of care. Resident #26 weighed 210 pounds (lbs) on admission and had no or unknown significant weight loss. He had a mechanically altered diet and supplemental tube feedings. Resident #26's care plan initiated on 7/26/22 revealed he had a potential nutritional problem related to receiving mechanically altered diet and tube feedings. The interventions included, in part: RD to evaluate and make diet change recommendations as needed. Weigh the resident at same time of day, using the same scale and record the weight. The care plan further revealed Resident #26 required tube feeding to assist in maintaining or improving his nutritional status. The interventions included, in part: consult the RD as needed and weigh as ordered. Resident #26's electronic medical record (EMR)	F 692	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 Nutrition/Hydration Status Maintenance Corrective action for resident(s) affected by the alleged deficient practice: On 10/14/2022, A corrective action was obtained for resident #26 by reweighing. Dietician, MD and RP notified of reweight. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current resident at risk for nutrition and hydration have the potential to be affected by the alleged deficient practice. On 10/14/2022, weight audit initiated by Director of Nursing. All weights for past 30 days were reviewed for all current residents to assure each had accurately recorded weights and no significant weight loss. All residents have had their weights, orders and plan of care reviewed by the Director of Nursing/Unit Coordinators on 10/15/2022 to ensure proper documentation in Point Click Care. No further concerns noted. On 10/14/2022, the Director of Nursing compared most recent resident weights to assess for significant weight loss (>5% in 30 days and >10% in 180 days). On	

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F 692	Continued From page 19 revealed the following recorded weights: -On 08/15/2022 Resident #26's weight was recorded as 208 lbs. -On 09/19/2022 Resident #26's weight was recorded as 186 lbs (10.58% weight loss). Review of the RD note dated 9/21/22 revealed Resident #26 was noted to have a weight discrepancy of 22 lbs less than his previous weight. The RD recommended staff reweigh Resident #26. During an interview on 9/29/22 at 2:06 PM the RD revealed Resident #26 was weighed monthly per facility protocol. When there was a weight discrepancy, she created a reweigh list and emailed it to the Unit Manager. The DON and the Administrator were also copied in this e-mail. The RD further revealed she sent two emails requesting that Resident #26 be reweighed, but it was not done. The RD stated reweighs should be done as soon as possible so she could add the appropriate interventions for the resident. An interview was conducted with the Director of Nursing (DON) on 9/28/22 at 12:30 PM which revealed he was unaware of Resident #26's weight loss and would have him reweighed. During an interview with Nurse Aide (NA) #7 on 9/28/22 at 3:45 PM she revealed she had been asked by the Director of Nursing to reweigh Resident #26 on that day and his reweigh was 186 lbs. She further revealed when she weighed residents, she reported the weights to the nurse and the Unit Manager. An interview was conducted with Nurse #3 on 9/29/22 at 11:45 AM that revealed weights were	F 692	10/17/2022, the physician, the responsible party and Registered Dietician were notified of most recent significant weight losses by Director of Nursing or Unit Coordinators. Registered Dietician and physician to review and suggest or order interventions. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: The Director of Nursing, Dietary Manager and Minimum Data Set Nurse will conduct weekly weight review to determine if new interventions are needed. On 10/5/2022, The DON began educating all clinical nursing staff (RN LPN, Medication Aide or Nurse Aide) regarding the importance of notification of weight losses of 5 lbs. or more and initiation interventions to prevent further weight loss. On 10/14/2022, the Director of Nursing and Unit Managers were re-educated by QA Nurse Consultant on Weight Management Policy/Nutrition and Hydration, monitoring and correcting inaccuracies in weights and on the importance of notifying the registered dietician, the responsible party and the physician of significant weight losses no less than weekly. The Director of Nursing will ensure that any licensed nurse (RN, LPN), Medication Aide or Nurse Aide who has not received this training by 10/17/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has	

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F 692	Continued From page 20 completed for residents on admission then monthly. If there was an issue with weight/nutrition the resident would have an order for weekly weights. She further revealed weights were followed by the Unit Manager. During an interview on 9/29/22 at 2:52 PM the Unit Manager indicated she thought she had reweighed Resident #26 but explained she had been very busy and she may have overlooked it. During an interview on 9/29/22 at 4:07 PM the Administrator explained resident weights were recorded in the electronic medical record and the RD then reviewed those weights. A list of residents that needed reweighed were communicated by e-mail. The Administrator revealed she was included in those emails, and she thought the Unit Manager or DON had ensured Resident #26 was reweighed. She further revealed reweighs should occur on the same day.	F 692	been sustained. The facility specific in-service will be provided to all agency Nurses and Nurse Aides who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by date of compliance. QUALITY ASSURANCE- Beginning 10/24/2022, the DON and/or designee will review 5 resident's including new admissions weight weekly using the QA tool for monitoring Weights Loss to ensure accuracy of documentation, notification and implementation of interventions as appropriate. Audits will be completed weekly x 4 weeks, then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance:10/17/2022	
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		10/17/22

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PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 21 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide sufficient staff to ensure 1 of 6 residents (Resident #37) received incontinence care when requested which resulted in the resident stating it made her feel "worthless, horrible, and bad" and she didn't deserve to be treated that way. Findings included: This tag is cross referred to: 1. F550: Based on observation, resident and staff	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F725- SUFFICIENT STAFFING	

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F 725	Continued From page 22 interviews and record review, the facility failed to provide care in a manner to maintain the resident's dignity by not providing incontinent care when requested. This resulted in Resident #37 crying while waiting for incontinent care and she reported it made her feel worthless, horrible, bad and "didn't deserve to be treated that way". This was evident for 1 of 6 residents who were reviewed for dignity and respect. 2. F677: Based on observations, resident and staff interviews, and record review, the facility failed to provide incontinence care when requested for 1 of 6 residents (Resident #37) reviewed for activities of daily living (ADL). Resident #37 indicated she activated her call light at 7:00 am on 09/26/22 to request incontinence care and was not provided with care until 11:37 am. During an interview with Nursing Assistant (NA) #1 on 09/26/22 at 11:50am, NA #1 indicated that the facility needed more nursing assistants and more staff in the kitchen. She stated she felt this would help with the residents waiting so long to be cared for. NA #1 indicated she does the best she can with the care and treatment of the residents in the facility. An interview was conducted with the Director of Nursing (DON) on 09/28/22 at 7:47 am, and he indicated the Nursing Department was staffing challenged and he had knowledge of staff doing double work at the facility. DON indicated that they also had a lot of agency staffing to help in the facility. An interview was conducted with the Administrator on 09/29/22 at 3:15 pm. She	F 725	Corrective action for affected residents. A corrective action was obtained for resident #37 on 9/26/2022 when the incontinent care was provided by the certified nursing assistant (CNA). Corrective action for potentially affected residents. On 10/14/2022, a 100% review of staffing ratios, assignments and current temporary agency staff use were completed by the Director of Nursing (DON), Administrator, and Nurse Management team. On 10/14/2022, The DON also reviewed the staffing plan for call ins to assure a system was in place for obtaining fill in staff. The review revealed facility staffing sufficient for the facility based on ratios and acuity. Nursing staff to continue only signing up for extra shift during scheduled days off as needed. Dietary Manager and Cook hired for dietary department. Systemic changes On 10/14/2022, the Administrator began an in-service education to all full time, part time, agency and as needed licensed nurses (RN, LPN), Medication Aide and certified nurse aide (CNA). Topics included: • The importance of staff call-outs, notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically incontinent care. • The Administrator and Director of Nursing will review daily staffing sheets at the morning stand up meeting to ensure staff is scheduled to meet the ADL and Assessment needs of the residents.	

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F 725	Continued From page 23 indicated that staffing was a challenge in the facility. However, her expectation was for staff to provide care and treatment for all residents in a timely manner.	F 725	• Educate scheduler related to call outs and who to report callouts to, to ensure proper staffing ratios The Director of Nursing will ensure that any Licensed Nurse, Medication Aide or CNA who has not received this training by 10/17/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Licensed Nurses, Medication Aides, and CNA's who give residents care in the facility. Additionally, Facility currently entered into contract with three staffing agencies to ensure sufficient staff available to meet the needs of residents. Quality Assurance Beginning the week of 10/24/2022, The Director of Nursing or the Administrator will monitor this issue using the Survey Quality Assurance Tool for Sufficient Staffing. The review will consist of reviewing staffing ratios and assignments to include resident acuity, and reviewing for any grievance reports related to staffing from previous day 3 x a week for 4 weeks then monthly x 2 months or until resolved. Interventions will be implemented as appropriate. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator,	

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F 725	Continued From page 24	F 725	Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 10/17/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		10/17/22

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F 880	Continued From page 25 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with facility staff, the facility failed to	F 880	The statements made on this plan of correction are not an admission to and do	

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F 880

Continued From page 26

follow the manufacturer guidelines for cleaning and disinfection of a blood glucose meter that was stored in the medication cart prior to use for 1 of 1 resident observed (Resident #38). The blood glucose meter was stored in the medication cart and was not designated as an individual resident meter.

Findings included:

Review of the Facility Policy 'Glucometers' revised on 01/2011, noted 'to utilize individual glucometers for each resident' and the glucometer was to 'be cleaned and disinfected per manufacturer's guidelines.'

Review of the blood glucose meter manufacturer guidelines, provided by the Unit Manager revealed the meter should be cleaned and disinfected after use on each resident. The meter was only to be used on multiple patients when the manufacturer's disinfection procedures were followed. Clorox Healthcare Bleach Germicidal Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, CaviWipes1 and PDI Super Sani-Cloth Germicidal Disposable Wipes were approved for disinfection. 70% alcohol was not listed as approved for disinfection.

During an observation of medication administration on 09/28/22 at 9:19 AM Nurse #1 stated all residents were supposed to have their own blood glucose meters, but Resident #38 was a new admission and did not have his own meter.

Nurse #1 was observed on 9/28/22 at 9:25 AM as she walked into Resident #38's room with the blood glucose meter she had removed from the medication cart. She had gathered the required

F 880 (Plan of Correction)

not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.
F880 INFECTION CONTROL
Corrective action for affected residents.
For resident #38- On 9/28/2022 Resident assessed by DON. No acute distress noted. MD notified with no new orders. Glucometer noted on medication cart discarded. Nurse #1 verbally reeducated by QA Nurse Consultant related to Glucometer Use and Disinfecting.
Corrective Action for Potentially Affected Residents.
All current residents and staff have potential to be affected by deficient infection control practices. On 9/28/2022, the Director of Nursing completed Infection Control Rounds to determine if deficient practices noted related to disinfection of blood glucose meter. No issues noted. The Director of Nursing began education with all full-time, part-time, PRN, and agency licensed nurses on glucometer use and disinfecting per facility policy.
Systemic Changes
On 10/5/2022, the Director of Nursing began reeducation on glucometer use and disinfecting with return demonstration for all full-time, part-time, PRN and agency licensed nurses (RN. LPN) on blood

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F 880	Continued From page 27 supplies and went to his bedside. Nurse #1 was interviewed on 09/28/22 at 9:26 AM in Resident #38's room and asked how she knew the meter had been cleaned prior to use at this time. She said, "I don't know if it was cleaned, I have my own Lysol wipes on top of the cart and I would like to use those now." She returned to the medication cart outside the room. She was asked if Lysol wipes were approved to use and stated, "I haven't used them before on the meters." Nurse #1 then noted "I would like to use the alcohol wipe to clean the strip insertion site" and proceeded to clean only the insertion site with a 70% alcohol pad. When asked how long the meter needed to stay wet to be effective, she noted "I am not sure, I am just going to clean the whole meter with alcohol now." Nurse #1 cleaned the entire blood glucose meter with another 70% alcohol pad. Nurse #1 was observed going back into Resident #38's room on 09/28/22 at 9:29 AM and performed a blood glucose check on Resident #38 with the meter she had cleaned with 70% alcohol. An interview was conducted with Nurse #1 on 09/28/22 at 9:31 AM and she was asked if she had an orientation to the facility regarding the blood glucose meter disinfection. Nurse #1 stated "honestly no" and "I go to different facilities and learn as I go." Unit Manager (UM) #1 was interviewed on 09/28/22 at 12:15 PM regarding the process for blood glucose meters. She stated every resident that required blood glucose checks should have their own meter and supplies. The UM went to	F 880	glucose meter use and disinfection. This education is incorporated into new hire training for all licensed nurses (RN and LPN). Any nurse which has not completed education by 10/17/2022 will not be allowed to work until education has been completed. Any newly hired or agency licensed nurses will be in-serviced as part of their facility orientation. Root Cause Analysis: On 10/7/2022, a root cause analysis was completed for failure to following manufacturers guidelines for disinfecting blood glucose meter by the Director of Nursing. The root cause found for failure to disinfect blood glucose meter per manufacturer guidelines were lack of knowledge, lack of oversight and deviation from trained policies and procedure. Quality Assurance Beginning 10/24/2022, the Director of Nursing or designee will complete 5 observations weekly x 4 weeks then monthly x 2 to ensure that staff are following manufacturers guidelines for disinfection and ensuring glucometers not stored on medication cart. QA Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse,	

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F 880	Continued From page 28 the supply room, revealed the area where the supplies were kept and how the kit should have been put together. She provided the blood glucose meter instruction guide for the meter used. On 09/28/22 at 12:43 PM the Director of Nursing (DON) provided an orientation checklist for Nurse #1 with her signature and the Staff Development Coordinator's (SDC) signature. Review of the 'Agency Nurse Orientation' packet indicated for 'blood sugar meters, they were never to be shared between residents, when cleaning/disinfecting to use the facility approved bleach/product, and alcohol wipes were not effective in cleaning meters and were not to be used to clean/disinfect blood sugar meters.' The packet was signed and dated by Nurse #1 on 08/15/22. On 09/28/22 at 3:07 PM Nurse #1 verified it was her signature on the agency nurse competency form for blood sugar meters and stated she must have forgotten the orientation. A follow-up interview was done with Unit Manager #1 on 09/29/22 at 4:07 PM. She stated for blood glucose meters, every resident should have their own meter in their room, and if they did not, the nurse should get a meter for the resident. The UM noted the meter should always be cleaned with the approved disinfectant wipe and the manufacturer guidelines followed, keeping it wet according to the guidelines and cleaning before and after use. The DON was interviewed on 09/29/22 at 4:13 PM about the blood glucose meters. He said every resident was to have their own meter. The	F 880	Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director. Date of Compliance: 10/17/2022	

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F 880	Continued From page 29 DON noted Nurse #1 should have disinfected the meter with the appropriate cleaning agent before and after use. An interview was conducted on 09/29/22 at 4:56 PM with the Administrator regarding blood glucose meters. She stated each resident should have their own meter and when Nurse #1 took the meter out of the medication cart, she should have cleaned it. She said the manufacturer guidelines should have been followed and the meter was to be cleaned before and after use.	F 880		