STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345091	A. BUILDING ______ B. WING ______	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE AT THE VILLAGE AT BROOKWOOD	**1820 BROOKWOOD AVENUE BURLINGTON, NC 27215**

(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 02/28/23 through 03/03/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # RNBV11.	E 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		3/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/21/2023

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 561	Continued From page 1 by: Based on record review, and resident, staff, and hospice interviews, the facility failed to honor residents' bathing preference and preferred number of showers per week for 2 of 3 residents (Resident #20 and Resident #11) reviewed for choices. The findings included: 1. Resident #20 was admitted to facility 2/11/20 with a diagnoses that included, venous insufficiency (peripheral) improper functioning of the vein valves in the leg that can cause swelling, muscle weakness, chronic kidney disease and difficulty walking, The significant change Minimum Data Set (MDS) assessment dated 12/2/22 indicated that Resident #20 was cognitively intact, had no rejection of care behaviors and was totally dependent on one person for bathing. The MDS further indicated it was very important for Resident #20 to choose between a tub bath, shower, bed bath or sponge bath. Resident #20 also received hospice care while at the facility. A review of the undated facility shower schedule revealed Resident #20 was scheduled for a shower on Tuesday and Thursday by a hospice aide on day shift and Monday and Thursday by the facility. A review of the bathing record for Resident #20 documented that the facility provided partial bed bath every day from 2/25/23 through 3/4/23. On 2/28/23 at 12:58 PM an interview with Resident #20 revealed he used to be taken to the shower room but now he only got bed baths and	F 561	MDS Nurse interviewed and assessed resident #11 and resident #20 for shower preferences. Shower schedule and care plans have been updated for resident #11 and resident #20. Certified Nursing Assistant assignment sheets were updated to indicate residents� shower preferences. Facility completed an audit of current resident�s shower preferences on 3/8/23. All shower schedules and Care Plans were updated by MDS Nurse on 3/15/23 to reflect residents� preferences. Certified Nursing Assistant assignment sheets were updated to indicate residents� shower preferences. All residents will be assessed upon admission and quarterly for shower preferences. Care plans and shower schedules will be updated accordingly. Certified Nursing Assistant assignment sheets will be updated to indicate residents� shower preferences. MDS Nurse to provide education to all nursing staff on the updated shower preferences, care plans, and assignment sheets by 3/24/23. MDS Nurse will audit Point of Care (POC) on all residents� for shower accuracy and completion weekly times four (4) weeks, then random audits monthly for two (2) months. Nurse Management will review audits for accuracy and completion times three (3) months.	

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F 561	Continued From page 2 he didn't know why. Resident #20 stated he preferred showers over bed baths and had told the staff on admission and a couple of other times, but he couldn't remember when. On 3/2/23 at 8:55 AM, an interview with Nurse #2 revealed that the facility staff no longer gave baths or showers to Resident #20 due to hospice being responsible for giving them. Nurse #2 stated that hospice staff gave him baths on Tuesdays and Thursdays. The facility staff only provided a complete bath if Resident #20 required one. However, Resident #20 receives partial bed baths daily from facility staff. Nurse #2 further stated that she knew Resident #20 only liked to have showers and that his preferences were given to hospice upon admission to hospice services. On 03/02/23 at 12:00 PM an interview with the Hospice Nurse Aide revealed she only gave bed baths per Resident #20's hospice care plan. On 3/2/23 2:34 PM, a phone interview with the Hospice Nurse who took care of Resident #20 revealed that hospice provided only bed baths to the residents receiving hospice services due to weakness. The hospice nurse stated they did not evaluate the residents to determine if they could tolerate being given showers and that they only provided bed baths to their residents. An interview with the Director of Nursing (DON) was completed on 3/2/23 at 2:34 PM. DON stated Resident #20 would need to be assessed to ensure that he could safely have a shower. The DON stated facility staff could assist hospice staff with resident showers. The DON explained her goal would be for Resident #20 to receive his	F 561	Nurse Management will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance. Date that corrective action will be complete: 3/24/23.	

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F 561	Continued From page 3 showers as requested/per his choice. The DON expressed that communication between hospice staff and facility staff needs to be better. 2. Resident #11 was admitted to facility on 8/18/21. The significant change Minimum Data Set (MDS) assessment dated 9/7/22 indicated that it was very important for Resident #11 to choose between receiving a tub bath, shower, bed bath, or sponge bath. The quarterly MDS assessment dated 12/5/22 indicated that Resident #11 was cognitively intact and had no rejection of care behaviors. Resident #11 required extensive physical assistance from two persons during bathing. A review of the undated facility shower schedule revealed Resident #11 was scheduled for a shower on Tuesdays and Thursdays on the day shift. A review of the Bathing Record for Resident #11 from 2/14/23 to 3/2/23 revealed he received a shower on 2/14/23 (Tuesday), 2/15/23 (Wednesday), 2/21/23 (Tuesday), 2/23/23 (Thursday), 2/28/23 (Tuesday) and 3/2/23 (Thursday). A review of Resident #11's nursing progress notes from 12/28/22 to 2/28/23 in his electronic health record showed no documentation of shower refusals. An interview with Resident #11 on 2/28/23 at 11:58 PM revealed that he only received showers twice a week on Tuesdays and Thursdays since	F 561		

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F 561	Continued From page 4 he had been admitted at the facility. Resident #11 stated he preferred to have showers three times per week. Resident #11 stated that he had spoken to the Administrator a couple of weeks ago but had not heard back from her with an update. An interview with Nurse #1 on 3/3/23 at 10:45 AM revealed that she had been unaware that Resident #11 wanted an extra shower day and that if she had known about it, she would have spoken to the Nurse Manager to get the resident's shower schedule updated. An interview with Nurse Aide (NA) #3 on 3/3/23 at 10:50 AM revealed that she didn't know about Resident #11's request to receive an additional day for a shower. NA #3 stated that if a resident wanted to make any changes to their bathing schedule, she would notify the nurse and the Nurse Manager so the shower schedule would be updated accordingly. An interview with the Nurse Manager on 3/3/23 at 10:55 AM revealed that if a resident wanted to make updates to their bathing schedule, then the facility would try to honor each resident's preference. The Nurse Manager stated that Resident #11 had spoken to her about a week ago that he wanted an extra shower day but she forgot to update the shower schedule then so she would go ahead and update it now. An interview with the Director of Nursing on 3/3/23 at 2:15 PM revealed that she had been unaware of Resident #11's request to update his shower schedule. The DON stated that if there was an issue with bath schedules staff would need to let her know. The DON further stated the	F 561		

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F 561	Continued From page 5 Nurse Manager usually assessed the residents for shower preferences on admission and at least quarterly when assessments were due. An interview with the Administrator on 3/3/23 at 2:20 PM revealed that she had spoken with Resident #11 a couple of weeks ago, but he did not want changes made to his shower schedule at that time. She stated that she had informed the resident to let staff know of any preferences and if he wanted to change his shower days. The interview further revealed residents were assessed on admission and then quarterly and then whenever they wanted a change in shower days, they would let staff know and the schedule would be updated.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		3/24/23

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F 582	Continued From page 6 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services to 2 of 2 residents reviewed for	F 582	Business Office Manager/Billing Specialist issued CMS-10055 SNF-ABN letters to resident #4 and resident #6, as well as their Responsible Party explaining Medicare days remaining.	

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F 582

Continued From page 7

beneficiary notification review (Residents #4 and #6).

The findings included:

1. Resident #4 was admitted to the facility on 8/19/22.

A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter was issued and signed by Resident #4 on 10/10/22. The letter explained Medicare Part A coverage for skilled services would end on 10/12/22. Resident #4 remained in the facility at the time the survey was being conducted from 2/28/23 through 3/3/23.

A review of the medical record revealed a CMS-10055 SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice) was not provided to Resident #4 or their Responsible Party.

On 3/2/23 at 2:00 pm an interview was completed with the Business office Manager (BOM). The BOM confirmed they issued the CMS-10123 NOMNC once notified of Resident #4 Medicare Part A coverage for skilled services was ending. The BOM stated that they were unaware the CMS-10055 SNF-ABN was also required for a resident remaining in the facility. The BOM confirmed that neither Resident #4 nor Resident #4's Responsible Party was issued a CMS-10055 SNF-ABN prior to Medicare Part A services ending.

An interview was completed with the Administrator on 3/2/23 at 3:52 pm. She revealed that when a resident was coming off Medicare Part A services and the resident had days

F 582

Executive Director provided education to Business Office Manager/Billing Specialist on instructions of when to issue an Advance Beneficiary Notice of Non-Coverage (ABN) on 03/20/23. Executive Director to complete an audit of all residents utilizing their Medicare coverage since 01/01/23 to ensure that resident(s) and Responsible Parties are aware of the Advance Beneficiary Notice of Non-coverage and remaining Medicare days available (if any) by 03/24/23.

Executive Director will audit all residents utilizing their Medicare coverage weekly times four (4) weeks and then monthly thereafter to ensure that ABN Form is issued appropriately.

Executive Director will report the findings of the audits in the QAPI Meetings to ensure compliance The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance.

Date that corrective action will be complete: 3/24/23.

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F 582	Continued From page 8 remaining a SNF-ABN should be issued. 2. Resident #6 was admitted to the facility on 11/21/22. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter was issued and signed by Resident #6 on 1/23/23. The letter explained Medicare Part A coverage for skilled services would end on 1/25/23. Resident #6 remained in the facility at the time the survey was being conducted from 2/28/23 through 3/3/23. A further review of the medical record revealed a CMS-10055 SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice) was not provided to Resident # 6 or their Responsible Party. On 3/2/23 at 2:00 pm an interview was completed with the Business office Manager (BOM). The BOM confirmed they issued the CMS-10123 NOMNC once notified of Resident #6 Medicare Part A coverage for skilled services were ending. The BOM stated she was unaware the CMS-10055 SNF-ABN was also required for a resident remaining in the facility. The BOM confirmed that neither Resident #6 nor Resident #6's Responsible Party was issued a CMS-10055 SNF-ABN prior to Medicare Part A services ending. An interview was completed with the Administrator on 3/2/23 at 3:52 pm. She revealed that when a resident was coming off Medicare Part A services and the resident had days remaining a SNF-ABN should be issued.	F 582		
F 657 SS=D	Care Plan Timing and Revision	F 657		3/24/23

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F 657	Continued From page 9 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the care plan after two falls for 1 of 3 residents (Resident #17) reviewed for falls. The findings included: Resident #17 was admitted on 10/19/22 with the	F 657	MDS Nurse updated the care plan to include interventions for resident #17 on 3/2/23 for falls that occurred on 1/27/23 and 2/25/23. MDS Nurse completed an audit of resident #17 fall care plan on 3/2/23. Director of Nursing to complete audit of all	

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F 657	Continued From page 10	F 657		

most recent re-admission date of 11/7/22 with diagnoses of unsteadiness on feet, history of falling, difficulty in walking and muscle weakness.

The quarterly Minimum Data Set (MDS) dated 1/24/23 indicated Resident #17 was moderately cognitively impaired. Resident #17 required limited assistance with transfer and extensive assistance with walking Her balance during transitions and walking was not steady and she was only able to stabilize with staff assistance. Resident #17 was frequently incontinent of bladder and required extensive assistance of one with toileting. The MDS further indicated that Resident #17 had two or more falls with no injury since the prior assessment.

Resident #17's care plan last reviewed on 2/1/23 indicated Resident #17 was at risk for falling related to impaired mobility with self-care deficits, cognitive impairment and falls history. Interventions included to toilet resident between 5-7 AM., provide toileting assistance frequently, put shoes on first thing in the morning when Resident #17 got dressed, frequent rounding for safety, call don't fall sign placed in view, administer medication as ordered and observe response and for side effects, assist to keep environment well-lit and free of clutter, assist with appropriate footwear to prevent slipping, encourage resident to assume a standing position slowly, encourage resident to use environmental devices, place bed in lowest position when care complete, place call light within reach, place personal items and frequently used items within reach, provide activities of daily living and mobility assistance as needed, provide verbal cues and reminders for safety and direction as needed.

residents falls since 2/1/23 to ensure that fall care plan interventions were updated by 3/24/23.

Director of Nursing provided education to MDS Nurse to ensure that all falls receive an intervention, and the fall care plans are updated appropriately to reflect intervention on 3/3/23. Medical Records will audit all resident falls for appropriate intervention and update to falls care plan weekly times four (4) weeks, then random audits monthly for five (5) months. Nurse Management will review audits for accuracy and completion times six (6) months.

Nurse Management will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance.

Date that corrective action will be complete: 3/24/23.

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F 657	Continued From page 11	F 657		

A review of the Observation Detail List Reports for Resident #17 indicated:
1/27/23 - Nurse #3 noted resident had an unwitnessed fall in the dining room with no injury noted. Nurse #3 marked interventions to place resident in common area during time of wakefulness and to engage in activity.
2/25/23 - Nurse #4 noted resident had an unwitnessed fall in the bathroom with no injury noted. Nurse #4 marked an intervention of toileting schedule initiated.

A phone interview with Nurse #3 on 3/3/23 at 9:27 AM revealed the Nurse Manager should review all the notes and incident reports so she could update the care plan. Nurse #3 stated the nurses passed along in report about Resident #17's fall on 1/27/23 and they tried to keep her at the nurses' station to keep an eye on her and she relayed to other staff members to watch her.

A phone interview with Nurse #4 on 3/3/23 at 1:22 PM revealed she just told the nurse aides about placing Resident #17 on a toileting schedule which was what she marked as a new intervention whenever she fell on 2/25/23. Nurse #4 stated she assumed the Nurse Manager read the incident reports and that she updated the care plans after each fall.

An interview with the Nurse Manager on 3/3/23 at 2:00 PM revealed she was responsible for updating the care plans and she usually looked at the reports and nursing notes daily. The Nurse Manager stated she did not update Resident #17's care plan after she fell on 1/27/23 and 2/25/23 and could not recall any interventions that were implemented for those falls.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE AT THE VILLAGE AT BROOKWOOD	**1820 BROOKWOOD AVENUE BURLINGTON, NC 27215**

(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 657	Continued From page 12 An interview was completed with the Director of Nursing on 3/3/23 at 2:51 PM. She stated that Resident #17's care plan should have been updated with interventions after each fall.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to assess a resident for injury before being moved after a fall for 1 of 3 residents (Resident #17) reviewed for falls. The findings included: Resident #17 was admitted on 10/19/22 with the most recent re-admission date of 11/7/22 with diagnoses of unsteadiness on feet, history of falling, difficulty in walking and muscle weakness. The quarterly Minimum Data Set (MDS) dated 1/24/23 indicated Resident #17 was moderately cognitively impaired. Resident #17 had no rejection of care behaviors and required limited assistance with transfer and extensive assistance with walking in the room and locomotion on unit. Her balance during transitions and walking was not steady and she was only able to stabilize with	F 684	Unit Manager provided education to NA #2 that when any resident has a fall that a licensed nurse must assess the resident before he or she can be moved on 3/13/23. MDS Nurse to complete audit of all residents falls since 2/1/23 to ensure that proper procedures were followed when a fall occurs by 3/24/23. MDS Nurse will continue to audit weekly times four (4) weeks, then random audits monthly for two (2) months. Nurse Management will review audits for accuracy and completion times three (3) months. MDS Nurse to provide education to all nursing staff on the proper falls procedures by 3/24/23.	3/24/23

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F 684 Continued From page 13

staff assistance. Resident #17 had no impairments in range of motion to both upper and lower extremities. The MDS further indicated that Resident #17 had two or more falls with no injury since the prior assessment.

Resident #17's care plan last reviewed on 2/1/23 indicated Resident #17 was at risk for falling related to impaired mobility with self-care deficits, cognitive impairment and falls history. Interventions included to provide toileting assistance frequently, frequent rounding for safety, call don't fall sign placed in view and assist to keep environment well-lit and free of clutter.

A review of the Observation Detail List Report dated 2/9/23 indicated Resident #17 fell in the bathroom. Nurse #5 wrote "CNA (Certified Nursing Assistant) stated she fell in the bathroom, and I got her up." Resident #17 denied any pain. No apparent injury noted. Resident #17 stated she was doing what she wasn't supposed to do. Nurse #5 encouraged Resident #17 to use call bell for assistance.

An interview was conducted by phone with Nurse #5 on 3/2/23 at 7:25 PM. Nurse #5 stated that the Nurse Aide (NA) #2 had come to her and told her that Resident #17 had fallen in the bathroom and that she had gotten her up and put her in the bed. Nurse #5 then went to Resident #17's room and did a complete assessment and did not note any injury. Nurse #5 also told NA #2 to always let a nurse assess a resident's condition for injury prior to moving them after a fall.

A phone interview was conducted with NA #2 on 3/3/23 at 2:00 PM. NA #2 stated she could not

F 684

Nurse Management will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance.

Date that corrective action will be complete: 3/24/23.

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F 684	Continued From page 14 recall the incident regarding Resident #17's fall but she knew she was not supposed to move a resident after a fall without notifying the nurse first. An interview completed with the Director of Nursing on 3/3/23 at 2:51 PM revealed she was not aware of Resident #17's fall incident on 2/9/23 but the nurse aide should have gotten the nurse prior to moving her after she fell.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to implement an intervention after a fall for a resident with a history of falls for 1 of 3 residents (Resident #17) reviewed for accidents. The findings included: Resident #17 was admitted to the facility on 10/19/22 with the most recent re-admission date of 11/7/22 with diagnoses of unsteadiness on feet, history of falling, difficulty in walking and muscle weakness. The quarterly Minimum Data Set (MDS) dated	F 689	MDS Nurse updated care plan and obtained physicians order for toileting between 5am and 7am for resident #17 on 3/2/23 for fall that occurred on 2/25/23 to reflect Toileting Program. Prior to fall, facility, and family initiated discharge plans for resident #17 to be discharged to Oregon on 3/6/23. MDS Nurse to complete audit of all fall procedures and interventions since 2/1/23 by 3/24/23. MDS Nurse will collaborate with nursing staff to develop, communicate, assign,	3/24/23

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F 689	Continued From page 15 1/24/23 indicated Resident #17 was moderately cognitively impaired. Resident #17 had no rejection of care behaviors and required limited assistance with transfer and extensive assistance with walking in the room and locomotion on unit. Her balance during transitions and walking was not steady and she was only able to stabilize with staff assistance. Resident #17 had no impairments in range of motion to both upper and lower extremities. The MDS further indicated that Resident #17 had two or more falls with no injury since the prior assessment. Resident #17's care plan last reviewed on 2/1/23 indicated Resident #17 was at risk for falling related to impaired mobility with self-care deficits, cognitive impairment and falls history. Interventions included to toilet resident between 5-7 am, provide toileting assistance frequently, put shoes on first thing in the morning when Resident #17 got dressed, frequent rounding for safety, call don't fall sign placed in view, administer medication as ordered and observe response and for side effects, assist to keep environment well-lit and free of clutter, assist with appropriate footwear to prevent slipping, encourage resident to assume a standing position slowly, encourage resident to use environmental devices, place bed in lowest position when care complete, place call light within reach, place personal items and frequently used items within reach, provide activities of daily living and mobility assistance as needed, provide verbal cues and reminders for safety and direction as needed. A review of the Observation Detail List Report dated 2/25/23 filled out by Nurse #4 indicated Resident #17 was observed on the floor in the bathroom sustaining no injury and a toileting	F 689	and document appropriate fall interventions. MDS Nurse to provide education to all nursing staff falls procedures and interventions by 3/24/23. MDS Nurse will audit all falls and appropriate interventions weekly times four (4) weeks, then random audits monthly for five (5) months. Nurse Management will review audits for accuracy and completion times six (6) months. Nurse Management will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance. Date that corrective action will be complete: 3/24/23.	

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F 689	Continued From page 16	F 689		

schedule was initiated.

A review of the Observation Detail List Report dated 2/28/23 filled out by Nurse #4 indicated that Resident #17 was observed on floor in her room. Resident #17 was in front of a chair facing her recliner sitting up on her bottom. Nurse #4 noted bruising to Resident #17 left hip/buttock. The intervention marked by Nurse #4 was a toilet schedule was initiated. An x-ray was obtained on 2/29/23 of Resident #17 left knee due to continuing complaints of pain, the x-ray result was no acute injury.

A phone interview with Nurse #4 on 3/3/23 at 1:22 PM revealed she just told the nurse aides about placing Resident #17 on a toileting schedule which was what she marked as a new intervention whenever she fell on 2/25/23 and on 2/28/23. Nurse #4 did not explain what a toileting schedule was to the staff or the times that the nursing assistants should take Resident # 17 to the restroom.

An interview with Nurse Aide (NA) #4 was conducted on 3/2/23 at 1:15 PM. NA #4 stated that she was assigned to Resident #17 when she worked, and that Resident #17 was not on a toileting schedule and never had been that she was aware of. NA #4 further stated Resident #17 usually let staff know during the day if she needed to use the bathroom and NA #4 also asked Resident #17 before and after meals.

Resident #17 was interviewed on 3/1/23 at 9:04 AM she stated that she was coming out of the bathroom and fell on 2/28/23. She also stated that she hurt her hip and knee but that the nurse had given her pain medication. Resident #17

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F 689	Continued From page 17 revealed she fell almost every day because she did not use the call light when she needed to use the bathroom. Resident #17 revealed that staff comes in her room when she does use the light but not at any other times that she can remember. An interview was completed with the Nurse Manager on 3/3/23 at 2:00 PM revealed she was responsible for updating the care plans and she usually looked at the reports and nursing notes daily. The Nurse Manager stated she did not update Resident #17's care plan after she fell on 2/25/23 and 2/28/23 with a toileting schedule. An interview was completed with the Director of Nursing (DON) on 3/3/23 at 2:51 PM. She stated that a toileting schedule should have been implemented for Resident #17. The DON further stated that each resident was different and that the toileting schedule should have been set up to meet Resident #17's needs to prevent further falls while trying to use the bathroom.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 695	Nurse #1 immediately adjusted oxygen	3/24/23

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F 695	Continued From page 18 record review, the facility failed to provide oxygen therapy per physician orders for 1 of 1 resident reviewed for respiratory care (Resident #12). The findings included: Resident #12 admitted to the facility on 06/14/21. Resident #12 had diagnoses that included interstitial pulmonary disease, chronic respiratory failure with hypoxia and chronic systolic congestive heart failure. Review of the physician order dated 10/10/22 read in part: 3 liters oxygen (O2) via nasal cannula (NC) continuous. Resident #12's quarterly Minimum Data Set (MDS) dated 01/18/23 revealed severe cognitive impairment. Resident #12 was coded as receiving oxygen therapy. Review of Resident #12's care plan revised 01/24/23 revealed Resident #12 had oxygen therapy ordered and was at risk for onset of complications related to its use. The interventions included administer oxygen per Medical Doctor (MD) order. An observation was completed on 02/28/23 at 12:18 PM. Resident #12 was observed sitting up in bed eating independently with her NC in her nostrils. Resident #12's oxygen concentrator was observed at 2.5 liters. Resident #12 exhibited no signs or symptoms of distress. A follow up observation of Resident #12 was completed on 03/01/23 at 9:01 AM. Resident #12 was observed resting in bed with her NC in her nostrils. Her oxygen concentrator was observed	F 695	concentrator setting to three (3) liters at eye level. Nurse #1 also checked resident #12 oxygen saturations, which registered at 99%. MDS Nurse began providing education to all nursing staff on 3/1/23 on Oxygen Therapy procedures. Nurse Management completed audit of all residents receiving oxygen therapy to ensure accuracy of oxygen administration and proper procedures on 3/1/23. Nurse Management began providing education on 3/1/23 to all nursing staff on Oxygen Therapy and will be completed by 3/24/23. Nurse Management to ensure that oxygen administration to document on the Electronic Medical Record (EMAR), oxygen administration is indicated on the nursing assistant assignment sheet and visual checks of appropriate oxygen settings for three (3) days a week for times four (4) weeks, then weekly times four (4) weeks, then monthly for three (3) months. Nurse Management will review audits for accuracy and completion times five (5) months. Nurse Management will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance.	

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F 695	Continued From page 19 at 2.5 liters. Resident #12 exhibited no signs or symptoms of distress. An additional observation was completed on 03/01/23 at 3:49 PM. Resident #12 was observed with her NC in her nostrils. The oxygen concentrator was set at 2.5 liters. Resident #12 exhibited no signs or symptoms of distress. An interview was completed on 03/01/23 at 4:34 PM with the first shift Nurse Aide (NA) #1. NA #1 stated Resident #12 was total care but could feed herself. NA #1 further revealed that NAs do not manipulate the oxygen setting on the concentrators. She continued to explain the NAs only turn the oxygen on or off after exchanging from room concentrator oxygen to portable oxygen if the resident were to leave the room. NA #1 stated, "Resident #12's concentrator was always at 2.5 liters." NA #1 revealed she had not looked at the oxygen setting on 03/01/23, and usually only noticed the level when Resident #12 had to be switched from room concentrator oxygen to portable oxygen and back to room concentrator oxygen. An interview and observation were completed with Nurse #1 on 03/01/23 at 4:41 PM. Nurse #1 stated the Medication Administration Record (MAR) was checked off every shift, and that morning was the last time the oxygen setting was checked. Nurse #1 explained the oxygen setting was where the middle of the ball fell on a number line on the gauge of the oxygen concentrator. While in Resident #12's room, Nurse #1 communicated the ball was a little below three and it should be on three. Resident #12's oxygen saturation (amount of oxygen in the blood) was checked by Nurse #1 at 4:48 PM which read	F 695	Date that corrective action will be complete: 3/24/23.	

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F 695	Continued From page 20 98-99%. Nurse #1 was observed to adjust the oxygen concentrator setting to 3 liters. An interview was completed with the Director of Nursing (DON) on 03/01/23 at 4:50 PM. The DON stated NAs were familiar with the oxygen level for each resident because it was part of the resident's point of care (electronic Kardex system for NAs). The DON further revealed that the oxygen number line should be across the middle of the bubble. Nurses and NAs should check the rate of oxygen flow throughout the day. The DON continued to explain nurses should have checked the oxygen concentrator at least once per day to ensure correct oxygen settings as ordered by the MD as well as ensure the machine was working properly.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		3/24/23

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F 761	Continued From page 21 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and the Pharmacy Consultant, the facility failed to remove an expired medication from 1 of 1 medication room and discard an uncapped eye medication in 1 of 2 medication carts (East Hall). The findings included: a. An observation of the medication room with Nurse #2 on 3/3/23 at 10:04 AM revealed a box of Epinephrine (medication used for emergency treatment of severe allergic reactions) marked with an expiration date of 12/2022. Two autoinjector 0.3 milligram syringes which were unopened and unused were inside the manufacturer's box. This box of Epinephrine was available for use in the medication storage cabinet in the medication room. An interview with Nurse #2 on 3/3/23 at 10:15 AM revealed that she had been unaware of the Epinephrine being expired and that the medication room was usually audited and checked by the Nurse Manager as well as the Pharmacy Consultant. An interview with the Nurse Manager on 3/3/23 at 2:00 PM revealed that she was responsible for ordering medications as well as checking the medication room. The Nurse Manager stated she	F 761	Nurse Management immediately removed and disposed of uncapped eye medication and ordered a replacement on 3/3/23. Epinephrine was also removed and returned to pharmacy for disposal on 3/3/23. On 3/3/23 audit was completed by Nurse Management of all medication carts and medication storage room for proper storage and expiration dates. No other areas of concern identified. Nurse Management provided education to all licensed nurses on proper medication storage in mediation carts and medication room beginning on 3/3/23 and will be completed by 3/24/23. Nurse Management to audit medication carts and medication room weekly times four (4) weeks. Nurse Management/Contracted Pharmacist will then audit monthly thereafter. Nurse Management will report the findings of the audits in the QAPI Meetings to ensure compliance. The QAPI Committee (Medical Director, Administrator, Director of Nursing, MDS Coordinator, Social Worker, Medical	

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F 761	Continued From page 22 did not know that there was expired Epinephrine in the medication storage room and that she had last checked the medication storage room about two weeks ago. A phone interview conducted with the Pharmacy Consultant on 3/3/23 at 2:15PM revealed that Epinephrine did not have an extended shelf life and that the expiration date on the box label was the expiration date and it should be discarded after that date. She stated that she did medication audits for the facility at least quarterly and that she completed the last audit on 12/5/22. An interview with the Director of Nursing (DON) on 3/3/23 at 2:45PM revealed that the medication storage room was audited frequently by the Nurse Manager as well as the Pharmacy Consultant. The DON stated that all expired medications should be removed promptly and reordered as necessary by the nurses and the Nurse Manager. b. An observation of the East hall medication cart with Nurse #2 on 3/3/23 at 10:30 AM revealed an uncapped Genteal eye gel (lubricant eye gel) in a small plastic bag for Resident #17. The uncapped end of the eye gel had pierced through the plastic bag and was exposed. An interview with Nurse #2 on 3/3/23 at 10:32 AM revealed that the ointment should have been discarded appropriately and another one should have been ordered from pharmacy. Nurse #2 also stated that the resident had an order to use the ointment in the evenings which was why she didn't notice it. An interview with the Nurse Manager on 3/3/23 at 2:00 PM revealed that if an uncapped eye gel had	F 761	Records, Therapy, Pharmacist, Facility Services, and Activities) is responsible for the ongoing compliance. Date that corrective action will be complete: 3/24/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345091	A. BUILDING ______ B. WING ______	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE AT THE VILLAGE AT BROOKWOOD	1820 BROOKWOOD AVENUE BURLINGTON, NC 27215

(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 761	Continued From page 23 been found in a medication cart the nurse should discard the eye gel and reorder the medication from pharmacy. An interview with the DON on 3/3/23 at 2:15PM revealed that the nurses should not have kept the uncapped eye gel in the medication cart, and they should have discarded it if they couldn't find the cap and re-ordered another one from the pharmacy.	F 761		