STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STEWART HEALTH CENTER	6920 MARCHING DUCK DRIVE CHARLOTTE, NC 28210

(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 03/04/24 through 03/07/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID K71111.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Investigation survey was conducted from 03/04/24 through 03/07/24. Event ID# K71111. The following intake was investigated NC00198962. Six of the 6 allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		4/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/28/2024

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure that the resident's Medical Order for Scope of Treatment (MOST) form was signed by the resident or resident representative for 1 of 2 residents reviewed for Advanced Directives (Resident #38). The findings included: Resident # 38 was admitted to the facility on 7/21/2021. A review of Resident #38's paper medical record located at the nursing station revealed a MOST form dated 6/8/2023. The MOST form indicated Resident #38 was a DNR and was signed by the Nurse Practitioner (NP). The MOST form did not have the required resident or resident representative signature on the front page of the document.	F 578	1. Resident #38 had no negative consequences from the alleged deficient practice. It is the practice of The Stewart Health Center to ensure resident's Medical Order for scope of Treatment (MOST) form is signed by the resident or resident representative. 2. All residents have the potential to be affected by incomplete Medical order for scope of treatment (MOST) forms. All current residents Medical order for scope of treatment (MOST) forms were reviewed by Social Services and any discrepancies have been addressed. 3. The advanced directives policy was reviewed and found to meet clinical standards. Education provided to Social Services and Health Center Licensed	

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F 578	Continued From page 2 A review of the active physician's order dated 11/30/2023 revealed Resident #38 was a DNR. Resident #38's care plan dated 1/11/2024 revealed goals and interventions for DNR (Do Not Resuscitate) to be implemented. The quarterly Minimum Data Set (MDS) dated 1/17/2024 revealed Resident #38 was severely cognitively impaired. An interview was conducted on 3/6/2024 at 9:55 am with Nurse #1. Nurse #1 reported that DNR and MOST forms were kept in a book at the nurse's station. He verbalized that the Medical Doctor (MD) or Nurse Practitioner (NP) and the resident or resident representative were required to sign the MOST form after it was completed. Nurse #1 reported that if the resident was unable to sign and the resident representative was not physically in the facility during the discussion of code status that a member of management would obtain the representative's signature the next time that they came to visit the resident. Nurse #1 was unaware that there was no resident or resident representative signature on Resident #38's MOST form and indicated that it should have been on the front of the MOST form. An interview was conducted on 3/6/2024 at 10:49 am with the Director of Nursing (DON). The DON reported that on admission, the Social Worker (SW) was responsible for identifying if the resident had an advanced directive in place. The SW would then get a copy of the advanced directive. She stated if a resident did not have an advanced directive, the SW would notify the MD to have them discuss advanced directives with	F 578	Nurses on the Advanced directive policy including ensuring the MOST form is sined by the resident representative. Additional systemic changes are being addressed through our quality assurance process described below. 4. The director of nursing or designee will: Audit compliance with all new admissions and newley changed Medical order for scope of treatment (MOST) forms having signatures as well as 3 random existing residents, 3x weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by April 5th, 2024.	

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F 578	Continued From page 3	F 578		

the resident and/or resident representative. The DON reported that education about advanced directives was provided by the MD or NP and should be dictated within their note on admission. The DON was unaware that there was not a resident or resident representative signature on Resident #38's MOST form and verbalized that there should be a signature by the resident or resident representative.

An interview was conducted on 3/7/2024 at 9:48 am with the SW. The SW reported that prior to admission, if a resident has an advanced directive, she would ask the resident or their representative to provide a copy of the document. She reported that the MD or NP would review the code status and advanced directives with the resident and/or resident representative on admission, provide education about code status, and complete the MOST form or DNR at that time. The SW verbalized that consent could be obtained over the phone and that the family would sign the document when they came into the facility, or telephone consent should be indicated on the MOST form, itself. The SW indicated that if the resident was unable to sign and their representative was not available, a golden DNR form was usually completed.

An interview was conducted on 3/7/2024 at 2:20 pm with the Administrator. The Administrator stated prior to a resident being admitted to the facility, the SW would obtain copies of any advanced directives that were already in place. If a resident did not have an advanced directive on admission, the SW would reach out to the MD or NP to have them discuss and educate the family about code status. The Administrator verbalized that a lot of conversations regarding code status

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F 578	Continued From page 4 occurred over the phone. She stated that they would try to get a resident representative to sign the MOST form the next time they came to visit. The Administrator was not aware that Resident #38's MOST form did not have a resident or resident representative signature and verbalized that it should be signed.	F 578		
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 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	F 582		4/5/24

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F 582	Continued From page 5 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 review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 1 of 3 residents (Resident #29) reviewed for beneficiary protection notification. The findings included: Resident #29 was admitted to the facility on 12/11/2023. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage	F 582	1. Resident #29 had no negative consequences from the alleged deficient practice. It is the practice of The Stewart Health Center to provide Advance beneficiary notice (SNFABN). 2. All residents with Medicare benefits have the potential to be affected. An audit of all the residents requiring SNFABNs in the past 30 days was completed. 3. The Medicare Advanced Beneficiary and Medicare Non-coverage Notices policy was reviewed and found to meet clinical standards. Education provided to	

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F 582	Continued From page 6 letter (NOMNC) was issued on 01/16/2024 to Resident #29's Responsible Party (RP) which explained Medicare Part A coverage for skilled services would end on 01/18/2024. Resident #29 was residing in the facility during the recertification survey conducted from 03/04/2024 through 03/07/2024. A review of the medical record revealed a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (ABN) was not provided to Resident #29 or their RP. An interview was conducted with the Social Worker and the Administrator on 03/06/24 at 10:05 AM. The Social Worker confirmed Resident #29 remained in the facility after their Medicare Part A benefit ended and a CMS-10123 NOMNC was issued to the RP however a CMS-10055 ABN was not provided. The Social Worker indicated she was unaware of the circumstances in which a CMS-10055 ABN was required to be issued to a resident and/or RP. The Administrator stated when a resident's Medicare Part A benefit was ending and they remained in the facility, a CMS-10123 NOMNC and a CMS-10055 ABN should be issued to the resident and/or RP.	F 582	health center business office director and social services director of policy and when the issue a notice and documentation in resident's medical record. 4. Business office director or designee will: Audit all of the Medicare records for timely completion of SNFABN weekly x 12 weeks, then monthly for a duration total of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained compliance. This will be sudmitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	
F 583 SS=G	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F 583		4/5/24

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F 583	Continued From page 7 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews the facility failed to maintain privacy during care and failed to obtain written consent for the use of cameras in residents' rooms for 2 of 2 samples residents reviewed for privacy (Resident #13 and #38). A reasonable person would expect privacy when care was being provided and not have a monitor screen showing them with private areas exposed and would feel humiliated and dehumanized.	F 583	1. Resident #13 and #38 had no negative consequences from the alleged deficient practice and the cameras in their rooms have been removed. It is the practice of The Stewart Health Center to maintain privacy during care and obtain a written consent for the use of cameras in resident rooms. 2. All 12 residents who had the electronic video monitoring cameras in place have	

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F 583	Continued From page 8 Findings included: 1. Resident #13 was admitted to the facility on 1/5/2024. The admission MDS dated 1/11/2024 revealed Resident #13 was moderately cognitively impaired and had not exhibited any behaviors. A review of Resident #13's medical record revealed that no written consent for camera usage was obtained. An observation was conducted on 3/4/2024 at 12:34 pm. Resident #13 did not have a roommate and a camera was visualized on top of the cabinet in Resident #13's room. A monitor for the associated camera in Resident #13's room was left unattended on the edge of an un-enclosed office desk. The camera monitor was able to be visualized approximately one foot away and was visible to visitors as they approached the desk. A telephone interview was conducted 3/4/2024 at 2:54 pm with Resident #13's Representative. The RR reported that nursing staff at the family had reached out to her about placing a camera in Resident #13's room because she had been getting up at night and had tried to get out of the facility. She reported that staff were so busy at night that having a camera in the room was an easy way for them to make sure Resident #13 did not get out of bed. The RR stated that she had agreed to placing a camera in the room and did not recall signing a consent form. An interview was conducted on 3/6/2024 at 9:50 am with Nurse #1. Nurse #1 stated Resident #13	F 583	since had them removed with the consent of the resident and/or reprsentative. No residents experienced any negative consequences. 3. The confidentiality of information and personal privacy policy has been reviewed and found to meet clinical standards. Education provided to health center nursing staff on the confidentiality of information and personal policy including maintaining privacy during care and obtain a written consent for the use of cameras in resident rooms. Additional systematic changes are being addressed through our quality assurance process described below. 4. The director of nursing or designee will: Audit compliance with not using cameras in resident rooms, 3x weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI until such time consitent substantial compliance has been achieved as determined by committee. The Administrator and director nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024.	

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F 583	Continued From page 9	F 583		

had a camera since she had been in her room. He reported that Resident #13 had fallen approximately two to three times prior to the camera being installed. Nurse #1 reported that camera monitors were never left unattended at the nurses station and that the monitors were portable and could be taken with the nurse if they had to leave the nurse's station.

An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). The DON stated several residents had cameras in their rooms. She reported that cameras remained on 24 hours per day and were not turned off. She reported that camera monitors should not be left unattended at the nurse's station, however there were times when a staff member would not be present at the nurse's station and camera monitors would be visible to visitors. The DON did report that anyone who approached the desk could potentially observe incontinence care on the camera monitor. The DON was not certain if a consent was obtained for camera usage for Resident #13.

An interview was conducted on 3/6/2024 at 12:39 pm with NA #3. NA #3 reported that Resident #13 had always had a camera in her current room. She reported that Resident #13 had been having issues with balance and had been visualized walking backwards with her walker, which had caused staff to be concerned about falling. NA #3 reported that the camera would be turned off, moved, or covered during incontinence care.

An observation was conducted on 3/7/2024 at 7:50 am. Resident #13 did not have a roommate. The camera monitor was able to be visualized

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F 583	Continued From page 10	F 583		

approximately one foot away and was visible to visitors as they approached the un-enclosed desk at the nurse's station. Resident #13 was observed sitting on the side of the bed with no brief, no pants, and her private areas were exposed as Nurse Aide Student #1 assisted her getting dressed.

An interview was conducted on 3/7/2024 at 10:16 am with NA #3. NA #3 reported Nurse Aide Student #1 had provided care for Resident #38 when she arrived on first shift (7:00 am to 3:00 pm). NA #3 stated she was not aware that Resident #13 had been exposed during care. She verbalized that a nurse was typically at the desk with the monitor and would move the camera angle away from the resident during care.

An interview was conducted on 3/7/2024 at 2:06 pm with the Administrator. The Administrator reported that several residents do have cameras in their rooms. She reported that cameras remained on for 24 hours per day, were never turned off, and that camera monitors were always to be attended at the nurse's station or at least out of view of visitors. She reported that facility staff did not obtain consent for camera usage because it was viewed as an extra level of supervision. The Administrator was unaware written consents were required for the usage of cameras.

2. Resident # 38 was admitted to the facility on 7/21/2021.

Resident #38's care plan dated 1/11/2024 revealed goals and interventions for falls which included staff being educated about not leaving camera monitors unattended.

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F 583	Continued From page 11	F 583		

The quarterly Minimum Data Set (MDS) dated 1/17/2024 revealed Resident #38 was severely cognitively impaired and had not exhibited any behaviors.

A review of Resident #38's medical record revealed that no written consent for camera usage was obtained.

An interview was conducted on 3/6/2024 at 10:01 am with Nurse #1. Nurse #1 reported that Resident #38 had a camera in his room since he started working at the facility in November of 2022. He reported that Resident #38 was able to walk at the time the camera was installed. He verbalized that Resident #38 would attempt to walk around in his room without assistance and had attempted to leave the facility to go home. Nurse #1 reported that camera monitors were never left unattended at the nurses station and that the monitors were portable and could be taken with the nurse if they had to leave the nurse's station. He stated that he thought either verbal or written consent was obtained for the usage of cameras but was unable to locate the consent for Resident #38.

An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). The DON stated several residents had cameras in their rooms. She reported that cameras remained on 24 hours per day and were not turned off. She reported that camera monitors should not be left unattended at the nurse's station, however there were times when a staff member would not be present at the nurse's station and camera monitors would be visible to visitors. The DON was not certain if a consent was obtained for

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STEWART HEALTH CENTER	6920 MARCHING DUCK DRIVE CHARLOTTE, NC 28210

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F 583	Continued From page 12	F 583		

camera usage for Resident #38.

An interview was conducted on 3/6/2024 at 12:47 pm with Nurse Aide (NA) #3. NA #3 reported that Resident #38 had a camera in his room for as long as she could remember. She reported that in the past Resident #38 would try to leave the building and expressed a desire to leave the facility. NA #3 reported that the camera would be turned off, moved, or covered during incontinence care.

An observation was conducted on 3/7/2024 at 7:50 am. Resident #38 had a camera mounted on the wall in his room and did not have a roommate. The camera monitor for Resident #38 was left unattended at the nurse's station. The camera monitor was able to be visualized approximately one foot away and was visible to visitors as they approached the un-enclosed desk at the nurse's station. Resident #38 was observed with his brief on and his pants around his ankles with both legs exposed while lying in bed as he received incontinence care by NA #3.

An interview was conducted on 3/7/2024 at 10:16 am with NA #3. NA #3 reported that she performed incontinence care for Resident #38 when she arrived on shift (3/7/2024). NA #3 stated she did not move the camera when she provided incontinence care, because the camera was positioned too high on the wall for her to reach. She verbalized that a nurse was typically at the desk with the monitor and would move the camera angle away from the resident during incontinence care.

An interview was conducted on 3/7/2024 at 2:06 pm with the Administrator. The Administrator

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F 583	Continued From page 13 reported that several residents do have cameras in their rooms. She reported that cameras remained on for 24 hours per day, were never turned off, and that camera monitors were always to be attended at the nurse's station or at least out of view of visitors. She reported that facility staff did not obtain consent for camera usage because it was viewed as an extra level of supervision.	F 583		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's	F 640		4/5/24

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F 640	Continued From page 14 assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete and transmit a discharge and a death Minimum Data Set (MDS) assessment within the required timeframe for 2 of 3 residents reviewed for resident assessments (Resident #52 and Resident #18). The findings included: 1. Resident #52 was admitted to the facility on 10/25/23. A review of Resident #52's medical record revealed that she was discharged to assisted living on 11/21/23.	F 640	1. Residents #52 and #18 had no negative consequences from the alleged deficient practice. It is the practice of the Stewart Health Center to transmit discharge and death MDS assessments in a timely manner that adheres to policy, procedure and to State and Federal guidelines and regulations. 2. All residents have the potential to be affected. A complete audit was performed of all residents MDS assessment transmissions in the past 6 months. In addition to the 2 MDS' identified during the annual review, 1 additional MDS assessment was identified as transmitted	

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F 640	Continued From page 15 A review of Resident #52's medical record revealed the last completed MDS was an admission MDS assessment dated 10/31/23. There was no discharge MDS assessment completed or transmitted. During an interview on 03/06/24 at 3:19 pm with the MDS Coordinator, she checked both the former electronic medical record system and the current electronic medical record system, and was not able to locate a discharge MDS in either system. She stated that she was not sure why a discharge MDS assessment was not completed or transmitted for Resident #52. During an interview on 03/07/24 at 1:07 pm with the Administrator, she stated that Resident #52's discharge MDS should have been completed or transmitted within 14 days, per the regulatory guidelines. 2. Resident #18 was admitted to the facility on 08/23/23. A review of Resident #18's medical record revealed that she expired in the facility, with her family at her bedside, on 10/14/23. A review of Resident #18's medical records revealed the last MDS completed was her annual MDS assessment dated 09/12/23. There was no death MDS assessment completed or transmitted. During an interview on 03/06/24 at 3:19 pm with the MDS Coordinator, she checked both the former electronic medical record system and the current electronic medical record system, and was not able to locate a death MDS assessment	F 640	late. 3. The transmittal requirements of MDS policy were reviewed and found to meet clinical standards. Education was provided to the MDS nurse on the policy for transmitting MDS assessments, along with State and Federal guidelines. Additional systemic changes are being addressed through our quality assurance process described below. 4. MDS coordinator or designee will: Review all discharge and death MDS assessments for timely transmission, weekly X 12 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time conssitent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	

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F 640	Continued From page 16 in either system. She reported that a death MDS assessment was probably not done due to the trainings being completed on the facility's new electronic medical record system. During an interview on 03/07/24 at 1:07 pm with the Administrator, she stated that Resident #18's death MDS assessment should have been completed and transmitted within 14 days, per the regulatory guidelines.	F 640		
F 641 SS=D	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 observations, record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for functional limitations in range of motion, and anticoagulant medication for 2 of 4 residents reviewed for accuracy of assessments (Residents #38 and #209). Findings included: 1. Resident #38 was admitted to the facility on 7/21/2021 with diagnoses which included muscle weakness. The quarterly Minimum Data Set (MDS) dated 1/17/2024 indicated Resident #38 had severe cognitive impairment, no impairment of the lower extremities, and required partial to moderate assistance from sitting to standing.	F 641	1. Resident #38 and #209 experienced no negative consequences from the alleged deficient practice. Resident's assessments were immediately modified. It is the practice of The Stewart Health Center to accurately code the MDS for functional limitations in range of motion and anticoagulant medications. 2. All residents have the potential to affected. A complete audit was performed of all residents MDS assessments who have functional limitations in range of motion and receive anticoagulant medications in the past 3 months. Any concerns identified have been addressed and assessments modified. 3. The certifying accuracy of the resident assessment policy was reviewed and	4/5/24

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F 641	Continued From page 17 An observation was conducted on 3/5/2024 at 2:43 pm. Nurse Aide (NA) #1 and NA #2 were observed using a sit-to-stand mechanical lift to transfer Resident #38 from the wheelchair to the toilet and back to his wheelchair during incontinence care. An interview was conducted on 3/5/2024 at 2:47 pm with NA #1. NA #1 reported that Resident #38 required the use of a mechanical lift during transfers due to his inability to walk. An interview was conducted on 3/6/2024 at 2:55 pm with the MDS Coordinator. The MDS Coordinator reported she was aware that Resident #38 required maximal assistance during transfers. She reported she would only code impairment of the lower extremities if an extremity was broken, deformed, or paralyzed. An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). The DON reported the MDS Coordinator was responsible for accurately completing MDS assessments. The DON was not aware that Resident #38's MDS was not coded for impairment of the lower extremities and verbalized that it should have been. An interview was conducted 3/7/2024 at 2:18 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for accurately completing MDS assessments. She stated impairment of the lower extremities should be coded on the MDS. 2. Resident #209 was admitted to the facility on 2/15/2024 with diagnoses that included atrial fibrillation (irregular heart rhythm).	F 641	found to meet clinical standards. Education provided to health center MDS coordinator including accurately documenting functional limitations in range of motion and anticagulant medications on the MDS. Additional systemic changes are being addressed through our quality assurance process described below. 4. Director of Nursing or designee will: Audit 3 MDS assesments for accuracy, specifically related to functional limitations in range of motion and anticoagulant medications, weekly for 3 months, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee. The administrator and director of nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	

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F 641	Continued From page 18 A review of Resident #209's medical record revealed an active order dated 2/15/2024 for apixaban (anticoagulant medication used to prevent blood clots) 5 milligrams to be administered twice a day. A review of Resident #209's Medication Administration Record indicated Resident #209 had received apixaban daily starting on 2/15/2024. The admission Minimum Data Set (MDS) dated 2/21/2024 did not indicate Resident #209 had received anticoagulation medication. An interview was conducted on 3/6/2024 at 11:02 am with the Director of Nursing (DON). The DON reported that the MDS Coordinator was responsible for accurately completing MDS assessments. The DON was not aware that the use of anticoagulants had not been coded on Resident #209's MDS and verbalized that it should have been. An interview was conducted on 3/6/2024 at 3:27 am with the MDS Coordinator. The MDS coordinator reported she was aware that Resident #209 was on apixaban. She stated it was not coded correctly because she thought apixaban was an antiplatelet medication. An interview was conducted on 3/7/2024 at 2:22 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for accurately completing MDS assessments.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		4/5/24

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F 656	Continued From page 19 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 20 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to develop and implement a person-centered care plan for residents on anticoagulants (Resident # 209 and Resident #20), residents on psychotropic medications (Resident #210, #20, and #259), and a resident with a wander/elopement alarm (Resident #13) for 5 of 5 residents reviewed for development and implementation of a comprehensive care plan. Findings included: 1) Resident #209 was admitted to the facility on 2/15/2024 with diagnoses which included chronic atrial fibrillation (irregular heart rhythm). Resident 209's care plan dated 2/15/2024 did not include goals and interventions for the use of anticoagulants. A record review revealed Resident #209 had active orders dated 2/15/2024 for apixaban (blood thinner) 5 milligrams to be administered twice a day and was to be monitored for signs and symptoms of bleeding. An admission Minimum Data Set (MDS) dated 2/21/2024 indicated Resident #209 was moderately cognitively impaired.	F 656	1. Resident #209, #20, #210, #259, and #13 expeirenced no negative consequences from the alleged deficient practice and their care plans have been updated accordingly. It is the practice of The Stewart Health Center to implement a comprehensive person-centered care plan on all residents including concerns related to anticoagulant use, psychotropic medications, and wander/elopement alarms. 2. All residents with anticoagulant medicaton, psychotropic medication, and wander/elopement alarm usage have the potential to be affected. An audit has been completed for all residents receiving anticoagulant medications, psychotropic medications, and wander/elopement and care plans have been updated accordingly. 3. The care plan comprehensive and person-centered policy was reviewed and found to meet clinical standards. Re-education has been provided to health center nurse supervisros and MDS coordinator on this policy including care planning concerns related to anticoagulant use, psychotropic medications, and	

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F 656	Continued From page 21 A review of Resident #209's Medication Administration Record (MAR) for February 2024 and March 2024 revealed he had taken apixaban 5 milligrams twice daily since 2/5/2024. An interview was conducted on 3/6/2024 at 10:10 am with Nurse #1. Nurse #1 stated that Resident #209 was on apixaban and verbalized the resident should be monitored for signs and symptoms of bleeding. Nurse #1 reported he was unsure if the use of anticoagulants were included in the care plan for Resident #209. An interview was conducted on 3/6/2024 at 10:32 am with the Director of Nursing (DON). She stated that the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. The DON stated any resident on an anticoagulant should be monitored for signs and symptoms of bleeding. She reported the use of anticoagulants should be care planned and include goals and interventions. The DON was not aware Resident #209 did not have a care plan for anticoagulants and verbalized that he should have. An interview was conducted on 3/6/2024 at 2:49 pm with the MDS Coordinator. The MDS coordinator stated she was responsible for creating and updating care plans. She stated if a resident was prescribed anticoagulants, the care plan should include goals and interventions for anticoagulants. The MDS Coordinator verbalized she was not sure why goals and interventions for anticoagulants were not included on Resident #209's care plan. An interview was conducted on 3/7/2024 at 2:22	F 656	wander/elopement alarms. Additional systemic changes are being addressed through our quality assurance process described below. 4. Director of nursing or designee will: Audit a random selection of 5 resident's charts for comprehensive person-centered care plan completion, weekly x 12 weeks, hen monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision needed. The audit will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly review. 5. The facility will be in and remain in compliance by: April 5, 2024	

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pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She stated residents who received anticoagulants should have goals and interventions for anticoagulants on their care plan. The Administrator was not aware that goals and interventions for anticoagulant usage had not been care planned for Resident #209 and reported that it should have been.

2) Resident #210 was admitted to the facility on 1/22/2024 with diagnoses which included generalized anxiety disorder and delirium.

Resident #210's care plan dated 1/22/2024 did not include goals and interventions for psychotropic medications.

An admission Minimum Data Set MDS dated 1/29/2024 revealed Resident #210 was taking antipsychotic and antianxiety medications, and was cognitively intact.

A review of Resident #210's record revealed active orders dated 2/15/2024 for quetiapine fumarate (antipsychotic medication) 12.5 milligrams to be administered daily and every twelve hours as needed.

A review of Resident #210's Medication Administration Record (MAR) for February 2024 and March 2024 revealed she had taken quetiapine fumarate 12.5 milligrams daily since 2/16/2024.

An interview was conducted on 3/6/2024 at 10:32 am with the Director of Nursing (DON). She verbalized the MDS Coordinator was responsible

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for completing resident-specific care plans with goals and interventions. The DON stated when a resident was prescribed a psychotropic medication, they should be monitored for behaviors and included in their care plan. The DON was not aware that Resident #210 did not have a care plan with goals and interventions for psychotropic medications. She verbalized that it should have been care planned.

An interview was conducted on 3/6/2024 at 3:20 pm with the MDS Coordinator. The MDS coordinator stated she was responsible for creating and updating care plans. She stated any resident taking psychotropic medications should have goals and interventions for psychotropic medication use in their care plan. The MDS Coordinator did not know why goals and interventions for antipsychotic use were not included in Resident #210's care plan.

An interview was conducted on 3/7/2024 at 2:22 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She stated residents who received psychotropic medications should have goals and interventions for psychotropic medication use in their care plan. The Administrator was not aware that goals and interventions for psychotropic medication use had not been care planned for Resident #210 and reported that it should have been.

3) Resident #13 was admitted to the facility on 1/5/2024 with diagnoses which included insomnia.

Resident #13's care plan dated 1/5/2024 was not

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updated to include goals and interventions for a wander/elopement alarm.

An admission Minimum Data Set MDS dated 1/11/2024 revealed that Resident #13 was moderately cognitively impaired.

A record review revealed Resident #13 had active orders dated 2/5/2024 to check the functionality and placement of wander/elopement alarm every shift.

An observation was conducted on 3/4/2024 at 12:34 am. Resident #13 was observed sitting in a chair in her room with a wander/elopement alarm on her left ankle.

An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). She verbalized the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She was not aware that Resident #13 did not have goals and interventions for a wander/elopement alarm on her care plan and indicated that she should have.

An interview was conducted on 3/6/2024 at 2:53 pm with the MDS Coordinator. The MDS coordinator stated she was responsible for creating and updating care plans. She stated goals and interventions for wander/elopement should be included in Resident #13's care plan and was not sure why it was not.

An interview was conducted on 3/7/2024 at 2:12 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She stated a care plan should

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include goals and interventions for wander/elopement if a resident wore a wander/elopement alarm. She was unaware that Resident #13's care plan did not include goals and interventions for wander/elopement and indicated that it should have.

4.) Resident #20 was admitted to the facility on 1/15/2020.

The quarterly Minimum Data Set assessment 1/6/2024 indicated Resident #20 was cognitively impaired and had received anticoagulant and psychotropic medications. The MDS also indicated Resident #20 had exhibited physical and verbal behaviors.

Review of Resident #20's physician orders from January 2024 through March 7, 2024, revealed he had an active order for daily apixaban (a blood thinning medication), quetiapine (an antipsychotic medication), and trazodone (an antidepressant medication).

Review of Resident #20's current Care Plan dated 1/14/24 did not reveal a care plan for monitoring anticoagulant or psychotropic medications, or behaviors.

An interview was conducted with the Minimum Data Set Nurse (MDS Nurse) on 3/6/24 at 3:15 PM. She stated if a resident was receiving anticoagulant or psychotropic medications, there should be care plans addressing their use and for monitoring behaviors. The MDS nurse reviewed the care plans for Resident #20 and verified there were no care plans for anticoagulant or psychotropic medication use or behaviors.

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An interview was conducted on 3/7/24 at 11:45 AM with the Administrator and the Director of Nursing (DON). They both stated if a resident received anticoagulant or psychotropic medications, they should have care plans in place which include monitoring. The Administrator explained this had been an oversight.

5.) Resident #259 was admitted to the facility on 2/12/24
The Admission Minimum Data Set assessment dated 2/18/2024 indicated Resident #259 was cognitively impaired and had received antianxiety and antidepressant medications.

Review of Resident #259's physician order dated 2/12/24 revealed she had active orders for as needed alprazolam (antianxiety medication) and daily escitalopram (antidepressant medication).

Review of Resident #259's current Care Plan 2/12/24 did not reveal a care plan for monitoring psychotropic medications.

An interview was conducted with the Minimum Data Set Nurse (MDS Nurse) on 3/6/24 at 3:15 PM. She stated if a resident was receiving psychotropic medications, there should be care plans addressing their use. The MDS nurse reviewed the care plans for Resident #259 and verified there were no care plans for psychotropic medication use.

An interview was conducted on 3/7/24 at 11:45 AM with the Administrator and the Director of Nursing (DON). They both stated if a resident received psychotropic medications, they should have care plans in place which include

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F 656	Continued From page 27 monitoring. The Administrator explained this had been an oversight.	F 656		
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 observations, record review, and staff interviews the facility failed to secure a mechanical lift and wheelchair during a transfer for 1 of 2 residents reviewed for Accidents (Resident #38). Findings included: Resident # 38 was admitted to the facility on 7/21/2021 with diagnoses which included lack of coordination, muscle weakness, and essential tremors. The Minimum Data Set (MDS) dated 1/17/2024 revealed Resident #38 required partial to minimal assistance for sit-to-stand and toileting transfer, had no impairment of upper and lower extremities, did not require the use of a mechanical lift, and was severely cognitively impaired. Resident #38's care plan dated 1/11/2024 did not include goals or interventions for using a	F 689	1. Resident #38 experienced no negative consequences from the alleged deficient practice. It is the practice of The Stewart Health Center to secure a mechanical lift and wheelchair during resident transfers. 2. All residents utilizing mechanical lifts have the potential to be affected. Licensed Nurses and CNAs recieved re-education on transfer device policy and procedure, and mechanical lift competencies. 3. The using a mechanical lifting machine policy have been reviewed and found to meet clinical standards. Education provided to health center nursing staff on the using a mechanical lifting machine policy including securing the mechanical lift and the wheelchair during transfer. Additonal systemic changes are being addressed throught our quality assurance process described below.	4/5/24

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F 689	Continued From page 28 mechanical lift. An observation was conducted on 3/5/2024 at 2:43 pm of Resident #38 as he received incontinence care. Nurse Aide (NA) #1 and NA #2 were observed as they transferred Resident #38 from his wheelchair to the toilet using a mechanical lift. As Resident #38 was moved from a sitting to standing position using the mechanical lift, the wheels on both the mechanical lift, the wheelchair remained unlocked, the NAs did not steady the lift or the wheelchair. Resident #38 was transferred to the toilet and NA #1 was observed lowering the lift without locking the wheels on the mechanical lift. After incontinence care was performed by NA #2, Resident #38 was raised using the mechanical lift by NA #1 and the wheels remained unlocked. Resident #38 was then transferred back to his wheelchair using the mechanical lift. As he was lowered back into his wheelchair, the wheels on both the mechanical lift and the wheelchair remained unlocked, and NAs were standing away from the lift and wheelchair during the process of raising and lowering the lift. An interview was conducted on 3/5/2024 at 2:47 pm with NA #1. NA #1 reported she typically worked on Resident #38's hall during the dayshift (7:00 am to 3:00 pm) and verbalized she had received education on using a mechanical lift and transferring residents. NA #1 verbalized she was aware that wheels on both the mechanical lift and wheelchair should be locked during a transfer. She reported she did not think that it was necessary because there were two NA's present during the transfer. NA #1 verbalized she would have used the locks on the lift and wheelchair if she had been doing the transfer by herself.	F 689	4. The director of nursing or designee will: Audit 2 random lift transfers for proper use of transfer technique, 3X weekly for 8 weeks, then weekly for 8 weeks, the monthly for a total duration of 12 months. Additionally, mechanical lift competencies will occur with three random health center nursing staff weekly for a total duration of 6 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024.	

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An interview was conducted on 3/5/2024 at 2:52 pm with NA #2. NA #2 reported that while using a lift and transferring residents, the wheels on both the wheelchair and mechanical lift should be locked. NA #2 verbalized the wheels were not locked because two NA's were present during the transfer. She reported she would have locked the wheels on the lift and wheelchair if she was by herself.

An interview was conducted on 3/6/2024 at 10:54 am with the Director of Nursing (DON). The DON reported all staff completed competency checks when they were hired and annually. She reported NA's are educated about the use of mechanical lifts and transfer of residents, which included locking the wheels on the mechanical lift and wheelchair prior to transferring the resident. The DON confirmed that NA #1 and NA #2 received education on mechanical lifts.

An interview was conducted on 3/6/2024 at 5:16 pm with the Staff Development Coordinator (SDC). The SDC reported NA's completed competency checks, which included the use of mechanical lifts and transferring residents, upon hire. She verbalized staff were educated about locking the wheels on the mechanical lift and wheelchair during transfers.

An interview was conducted on 3/7/2024 at 2:18 pm with the Administrator. The Administrator stated staff received education about mechanical lifts and transfers upon hire and on an as needed basis. She stated staff had received education about locking the wheels of a mechanical lift and wheelchair during transfers.

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F 758	Continued From page 30	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		4/5/24

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F 758	Continued From page 31 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a stop date for an psychotropic medication that was prescribed as needed for 2 of 2 residents reviewed for unnecessary medications (Resident #210 and #259). Findings included: 1) Resident #210 was admitted to the facility on 1/22/2024 with a diagnosis of delirium. An admission Minimum Data Set (MDS) dated 1/29/2024 revealed Resident #210 was prescribed antipsychotic medications, was cognitively intact, and had not exhibited any behaviors. Resident #210 was prescribed Seroquel (antipsychotic medication) 12.5 milligrams every 12 hours as needed for behaviors on 2/15/2024 with no end date. A review of the Pharmacist's Medication Regimen Review dated 2/21/2024 was conducted. The Pharmacist had recommended discontinuing the	F 758	1. Residents #210 and #259 had no negative consequences from the alleged deficient practice. It is the practice of the Stewart Health Center to ensure as needed psychotropic medications have a stop date. 2. All residents receiving as needed psychotropic medications have the potential to be affected. A comprehensive audit has been completed for all residents receiving as needed psychotropic medications for appropriate stop date. 3. The psychotropic medication use policy has been reviewed and found to meet clinical standards. Education provided to health center licensed nursing staff (registered nurses and licensed practical nurses) on the psychotropic medication use policy including as needed pyschotropic medications requiring a stop date. Education provided by administrative clinical nurse supervisor and staff developement coordinator, education began on receipt of 2567 and is	

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F 758	Continued From page 32 as needed order for Seroquel by 2/29/2024. A review of Resident #210's Electronic Medication Administration Record (EMAR) revealed Seroquel 12.5 milligrams every 12 hours as needed for behaviors was active from 2/15/2024 through 3/5/2024. An interview was conducted on 3/6/2024 at 9:33 am with Nurse #1. Nurse #1 stated residents who received antipsychotics were monitored for behaviors. He reported antipsychotics normally had an end date of 90 days or were indefinite. Nurse #1 reported he typically did not see end dates with Seroquel. He was unaware Resident #210's Seroquel order did not have a stop date. An interview was conducted on 3/7/2024 at 10:55 am with the Pharmacist. The Pharmacist stated she was aware that Resident #210 had an active as needed order for Seroquel with no stop date. She reported that she had sent a recommendation on 2/21/2024 to the facility to stop the as needed order for Seroquel after 14 days (2/29/2024). An interview was conducted on 3/6/2024 at 10:32 am with the Director of Nursing (DON). The DON stated residents prescribed antipsychotic medications should be monitored for behaviors and antipsychotic medications ordered on an as needed basis required a 14 day stop date. She was unaware Resident #210's as needed Seroquel order did not have an end date. An interview was conducted on 3/7/2024 at 2:03 pm with the Administrator. The Administrator stated residents who were prescribed as needed antipsychotic medications required a 14 day stop	F 758	ongoing to be completed by 4/5/2024. Additional systemic changes are being addressed through our quality assurance process described below. 4. Director of nursing or designee will: Audit all as needed pyschotropic physician orders for stop date, weekly 12 weeks, then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024.	

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date. She reported she was made aware on 3/5/2024 Resident #210 had an antipsychotic medication ordered with no stop date and had the issue addressed.

2.) Resident #259 was admitted to the facility on 2/12/24 with diagnoses that included: depression, anxiety, and unspecified dementia without behavioral disturbances.

Review of Resident #259's Care Plan dated 2/12/24 revealed Resident #259 did not have a care plan for psychotropic medication use or behaviors.

The Admission Minimum Data Set (MDS) assessment dated 2/18/2024 indicated Resident #259 was cognitively impaired and coded for antianxiety and antidepressant medication use. The MDS Indicated Resident #259 did not have any behaviors or rejection of care.

Review of Resident #259's physician order dated 2/12/24 revealed an order for Alprazolam (antianxiety medication) 0.25 mg every 24 hours as needed (PRN) for anxiety. The physician's order did not contain a stop date for the medication.

Review of Resident #259's electronic Medication Administration Record (eMAR) for the month of February 2024 revealed she received doses of Alprazolam on 2/18/24, 2/27/24, and 2/28/24.

An interview was performed with Nurse #1 on 03/06/24 at 9:33 AM. Nurse #1 stated there was usually an end date for PRN psychotropic medications that was usually 90 days or indefinite.

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F 758	Continued From page 34 On 03/06/24 at 10:32 AM an interview was completed with the Director of Nursing (DON). The DON stated PRN psychotropic medications should have a stop date and the stop date should be 14 days. An interview was conducted on 03/06/24 at 5: 22 PM with the Medical Director. He stated PRN psychotropic medications should have a stop date and the stop date should be 14 days. He stated he reviewed psychotropic medications during resident visits. He explained if he found a psychotropic medication that did not have a stop date, he would add a stop date or would discontinue the psychotropic medication whenever able. He stated the pharmacy did a wonderful job reviewing psychotropic medications for 14 day stop dates. He verbalized the nurses would also monitor for stop dates on psychotropic medications and notified him when they saw a PRN psychotropic medication that needed a stop date. An interview was performed on 3/7/24 at 3:45 PM with the Administrator. The Administrator explained that PRN psychotropic medications should have a stop date. She stated the stop date for PRN psychotropic medications should be 14 days.	F 758		
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	F 761		4/5/24

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F 761	Continued From page 35 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 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 staff interviews, the facility failed to secure resident medications left in an unattended medication cart for 1 of 2 medication carts (Dogwood Avenue medication cart). The findings included: A continuous observation of Dogwood Avenue was conducted on 03/04/24 from 11:51 am to 11:57 am. The Dogwood Avenue medication cart was observed with the lock not engaged as evidenced by the red dot on the lock being visible. There was no staff member at the medication cart. Several staff members, residents, and visitors were observed walking past the medication cart.	F 761	1. No residents were affected nor had any negative consequences from the alleged deficient practice. It is the practice of The Stewart Health Center to ensure medication carts are secured when unsupervised. 2. All residents have the potential to be affected. No residents experienced negative consequences from the alleged deficient practice. 3. The security of medication cart policy has been reviewed and found to meet clinical standards. Education provided to health center licensed nursing staff on the security of medication cart policy including	

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(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 36 On 03/04/24 at 11:57 am, Nurse #2 was observed approaching the Dogwood Avenue medication cart. An observation and interview were completed with Nurse #2 upon her return to the Dogwood Avenue medication cart. She placed her key in the unengaged lock and was stopped by the surveyor. The surveyor asked Nurse #2 to open the medication cart drawer prior to turning the key, and the drawer opened. The observation revealed various prescribed and over-the-counter medications and supplies, including eye drops, injectables, and oral medications for the residents on her unit. Nurse #2 explained that her normal practice was to lock the medication cart when she was not in its presence. She continued to explain that she would have pressed the lock in, ensured that the computer screen was locked, and kept the medication cart keys in her pocket at all times. Nurse #2 reported that she was not certain why she did not engage the lock when she stepped away from the medication cart. An interview with the Director of Nursing (DON) on 03/06/24 at 3:32 pm was completed. The DON reported that the medication cart should have been secured and locked unless the nurse was present at the cart. She stated that staff who noticed that the cart was unlocked should have immediately pressed the lock. Then, that staff member should have notified the nurse assigned to the cart that the unattended medication cart was unlocked. The DON verbalized that the nurse to which the medication cart was assigned was responsible for the medication cart and ensuring that it was secured.	F 761	securing the medication cart during the medication pass to prevent unauthorized entry. Additional systemic changes are being addressed through our quality assurance process descibred below. 4. Director of Nursing or designee will: Audit medication carts for secuirty, weekly 12 weeks, then monthly for a total of duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained complaince. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/5/24

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F 812	Continued From page 37 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain a clean ice cream freezer, label and date perishable food items stored in the walk-in cooler, and label and date perishable items in the reach-in refrigerator and ensure frozen items were sealed in the walk-in freezer. These practices had the potential to affect food served to residents. Findings included: 1. The initial observation of the ice cream cooler conducted on 3/4/2024 at 9:48 am revealed pink and brown-colored substances on all four walls of the cooler. An interview was conducted with the DM on	F 812	1. No residents were affected nor had any negative consequences from the alleged deficient practice. It is the practice of the stewart health center to maintain a clean ice cream freezer, label and date perishable food items stored in the walk-in cooler, label and date perishable items in the reach in refrigerator, and ensure frozen items are sealed in the walk-in freezer. 2. All residents have the potential to be affected.No residents have expeirenced any negative consequences. 3. The food receiving and storage policy and the refrigerator and freezers policy	

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F 812	Continued From page 38 3/7/2024 at 8:51 am. She reported the ice cream cooler was cleaned and sanitized daily. The DM stated the ice cream cooler was cleaned on 3/3/2024 and must have gotten dirty after she left. An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator reported the ice cream cooler should be clean and sanitary. She was not aware of the pink and brown-colored substance on the walls of the ice cream cooler. 2. The initial observation of the kitchen was conducted with the Dietary Manager (DM) on 3/4/2024 at 9:55 am. The initial observation of the walk-in cooler contained the following: -A package of crumbled blue cheese that had been opened with no label or date. -A package of shredded white cheddar cheese that had been opened with no label or date. - A package of shredded white/yellow cheese that had been opened with no label or date. An interview was conducted with the DM on 3/7/2024 at 8:51 am. The DM stated food is to be labeled and dated after being opened. She reported she had audited all food items in the kitchen on 3/3/2024 but the dietary aides must have opened items without labeling and dating them after she left. An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator stated all opened food packages were required to have a label and date. She was not aware of the opened packages of cheese without a label or a date. 3. The initial observation of the reach-in	F 812	have been reviewed and found to meet clinical standards. Education provided o health center dining services staff on the food receiving and storage policy and the refrigerator and freezers policy including labeling and dating or perishable items in the refrigerators, sealing items in the freexer, and maintaining a clean ice cream freezer. Additional systemic changes are being addressed through our quality assurance process described below. 4. The dining services director or designee will: Audit compliance with labeling and dating of perishable items in the refrigerators, sealing items in the freezer, and maintaining a clean ice cream freezer, 3x weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained complaince. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	

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F 812	Continued From page 39	F 812		

refrigerator conducted on 3/4/2024 at 10:06 am revealed a package of sliced American cheese that had been opened with no label or date.

An interview was conducted with the DM on 3/7/2024 at 8:51 am. The DM reported she had audited all food items in the kitchen on 3/3/2024 and a dietary aide must have opened the package of sliced cheese after she left.

An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator stated all opened food packages were required to have a label and a date. She was not aware of the opened sliced cheese without a label or a date.

4. The initial observation of the walk-in freezer conducted on 3/4/2024 at 10:10 am revealed the following:
-A package of hashbrowns that had been opened with no label or date.
-An unsealed bag of okra with no label or date.

An interview was conducted with the DM on 3/7/2024 at 8:51 am. The DM stated opened food packages were to be sealed, labeled, and dated. She stated she was not sure why the package of hashbrowns had no label or date and why a bag of okra was unsealed without a date in the walk-in freezer.

An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator stated all opened food packages were required to have a label and a date. She was not aware of the opened package of hashbrowns had no label or date and a bag of okra was unsealed without a date in the freezer.

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F 880 SS=F	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 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:	F 880		4/5/24

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F 880	Continued From page 41 (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 record review, Physician, and staff interviews, the facility failed to implement an infection prevention and control program plan, failed to implement an infection surveillance plan for monitoring and tracking infections in the facility, and failed to review infection control policies annually. This practice had the potential to affect 60 of 60 residents in the facility. Findings included:	F 880	1. No residents were affected nor had any negative consequences from the alleged deficients practice. It is the practice of The Stewart Health Center to implement an infection prevention and control program plan, to implement an infection surveillance plan for monitoring and tracking infections in the facility, and to review infection control policies annually.	

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F 880	Continued From page 42 The Infection Prevention and Control program policy (Revised October 2018) documented "The infection prevention and control program was coordinated and overseen by the infection prevention specialist (infection preventionist)", indicated "Infection Control Policies should be reviewed at least annually", and "Process surveillance and outcome surveillance are used as measures of the infection prevention control program (IPCP) effectiveness". The facility's infection control policy and procedure manual was provided by the administrator on entrance to the facility. The first page of the manual indicated "The Stewart Health Center has approved the following manual as its Infection Control Policy and Procedures Manual". The front page of the manual indicated "Version Date April 1, 2014". The bottom of the front page indicated the policy manual had been "reviewed and approved by" the Medical Director, Director of Nursing, and Administrator on 5/1/2019. An interview with the IP was completed on 3/6/24 at 4:30 PM. The Infection Preventionist (IP) stated she had been assigned to the IP role since September 2023 when the prior Director of Nursing (DON) left. She was unable to explain the surveillance process for tracking/ trending of infections or completing the antibiotic line listing. The IP was unable to provide policy and procedures for the facility's infection prevention and control program plan, surveillance of infections, or a list of reportable communicable diseases. A follow up interview was conducted on 3/7/24 at 9:40 AM with the IP. She stated she completed the North Carolina State Program for Infection	F 880	2. All residents have the potential to be affected. No residents have experienced any negative consequences. 3. The infection prevention and control policy was reviewed and found to meet clinical standards. Education was provided to infection preventionist and designee on the infection prevention and control policy implementing an infection surveillance plan for monitoring and tracking infections in the facility, and reviewing infection control policies annually. Education was provided by Maureen Bieker, clinical specialist on 4/3/2024. Additional systemic changes ae being implemented through the quality assurance process described below. 4. The director of nursing or designee will: Audit compliance with infection control surveillance program and completion of documentation 2x weekly for 2 months, weekly for 4 months and then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director of nursing will be responsible for sustained complaince. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	

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F 880	Continued From page 43	F 880		

Control and Epidemiology (NC SPICE) training online in April of 2023. She explained she became the facility's infection preventionist in September of 2023 after the Director of Nursing (DON) left. She stated that before September 2023 the prior DON had performed infection control duties. She stated she did not have much training on how to perform infection control duties, surveillance, line listing, or tracking/ trending of infections outside of NC SPICE training class. She said that the Regional Clinical Director would send new policies to the facility when they had updates. She stated when new policies were sent to the facility the facility would mark the review date at the top of the policy and sign the policy. She explained she did not have policies, but she would ask the Regional Clinical Director to send her the policies for: The Infection Prevention and Control Program Plan, Surveillance Policy, list of reportable communicable diseases, and Antibiotic Stewardship policy. The IP stated the Administrator, and the Director of Nursing (DON) were responsible for reviewing the facility's infection control policies annually.

3/7/24 11:00 AM The IP provided the following policies and indicated she had received the policies from the Regional Clinical Director today: Surveillance for Infections (Revised September 2017), Infection Prevention and Control Program (Revised October 2018), Outbreak of Communicable Disease (Revised September 2022), Reporting Communicable Diseases (Revised July 2014), Reportable Disease (Revised September 2022). The IP was not able to provide a list of reportable communicable diseases. There was not a review date or reviewer signature present on any of the above

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F 880	Continued From page 44	F 880		

policies provided. The IP stated if staff needed to access an infection control policy there was a copy of the Facility's Infection Control Policy and Procedures Manual located at the Nursing station.

An Interview was conducted on 3/7/24 at 11:18 AM with Nurse #3. She was unable to locate the facility's Infection Control Poly and Procedure Manual at the nurse's station. She stated if she needed access to an infection control policy, she had to ask the IP nurse.

An interview with the Medical Director was completed 3/6/24 at 5:22 PM. He stated the facility reviewed infection control during their quality assurance performance improvement meetings. He verbalized the facility notified him when an outbreak occurred. He explained the facility notified him of the COVID-19 outbreak that occurred from December 2023-January 2024 and stated he felt the facility did a good job with infection control and managing the outbreak.

An Interview was performed on 3/7/24 at 11:45 AM with the Administrator and the DON. They explained the IP was responsible for reviewing infection control policies annually. The Administrator stated the facility's infection control policies and procedures should be reviewed annually and with changes. They voiced they were unaware that the facilities infection control policies and procedures were not being reviewed annually. The Administrator stated she thought the failure occurred partially due to the facility's focus on transitioning to the new electronic computer system. They voiced they were unaware the IP was not completing a line listing for tracking/ trending of infections or obtaining

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F 880	Continued From page 45 diagnostic results for infections. The Administrator explained she thought the process failure was a result of the IP being trained in spring 2023 and at that time the prior DON was still doing IP duties. She stated when the prior DON left, they thought the new IP new how to do infection control, since she had completed the NC SPICE training. The Administrator voiced the new IP hesitated to ask questions and this got missed with the DON transition and the facility's focus on transitioning to the new electronic computer system. She stated when the facility was transferring to the new electronic computer system, they were focused on getting everything into the new system and things that should have gotten followed up on were not overseen well. She explained the components of the facility's infection control program not being completed and in place was likely related to the IP being new to the IP role.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an infection prevention and control program that established an antibiotic stewardship program with written protocols on	F 881	1. No residents were affected nor had any negative consequences from the alleged deficient practice. It is the practice of The Stewart Health Center to have an	4/5/24

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F 881	Continued From page 46 antibiotic prescribing, documentation of the indication, dosage, and duration of use of antibiotics. This was evident in 4 of 4 monthly surveillance data reviewed (December 2023, January 2024, February 2024, and March 2024.) Findings included: On 3/7/24 the Infection Preventionist (IP) provided the policy sent to her by the Regional Clinical Director. The Policy provided titled "Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes" was revised December 2016. The policy documented the antibiotic stewardship program will monitor and review all clinical infections treated with antibiotics, antibiotic utilization, identify specific situations not consistent with appropriate antibiotic use, and document all resident antibiotic regimens on the facility- approved antibiotic surveillance tracking form. The policy indicated the facility- approved antibiotic surveillance tracking form should include resident name, unit/ room number, date symptoms appeared, site of infection, date of culture, name of antibiotics, start date, stop date, total days of therapy, pathogen identified, outcome, and adverse events. During an interview with the Infection Preventionist (IP) nurse on 3/6/24 at 4:30 PM. The IP stated she had been assigned to the IP role since September 2023. The IP stated she had just started using an antibiotic line listing form in January. She stated prior to January she had not completed an antibiotic line listing form. A request to see the tracking of antibiotic use in the facility from December 2023 to March 2024 revealed the IP did not have an antibiotic line listing for the month of December 2023 and had	F 881	infection prevention and control program that established an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of indication, dosage, and duration of the use of anitbiotics. 2. All residents have the potential to be affected. No residents have expereicned any negative consequences. 3. The antibiotic stewardship policy was reviewed and found to meet clinical standards. Education was porvided to infection preventionist and designee onthe antibiotic stewardship policy including written protocols on antibiotic prescribing, documentation of indication, dosage, and duration of use of antibiotics. Education was provided on 4/3/2024 by Maureen Bieker, Clinical Specialist, the education given was on the policy for antibiotic stewardship. Additional systemic changes are being implemented through the quality assurance process described below. 4. The director of nursing or designee will: Audit complaince with infection control anitbiotic stewardship program and completion of documentation 2x weekly for 2 months, weekly for 4 months and then monthly for a total duration of 12 months. The results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by QAPI committee until such time consistent substantial compliance has been achieved as determined by the committee. The administrator and director	

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F 881	Continued From page 47 an incomplete antibiotic line listing for the month of January 2024. She stated she did not have the information for February 2024 and was currently working on the antibiotic line listing for the month of February 2024. She did not have an active current list of residents who were receiving antibiotics. During the interview she was able to search through the orders in the electronic computer system and provided a list of residents in the facility who were currently receiving antibiotics. The IP was unable to provide culture result information for residents who had received treatment for urinary tract infections. She stated if the antibiotic was started at the hospital or by a doctor's office, she did not request diagnostic or culture results. The IP nurse was unable to identify or describe the components of an antibiotic stewardship program or the infection surveillance process. An Interview was performed on 3/7/24 at 11:45 AM with the Administrator and the DON. They explained they were not aware the facility did not have an active antibiotic stewardship program. They voiced that they were unaware the Antibiotic Stewardship policy was not being followed. The Administrator stated she thought the failure occurred partially due to the facility's focus on transitioning to the new electronic computer system. They voiced they were unaware the IP was not completing infection control tasks related to antibiotic stewardship, an antibiotic line listing for tracking/ trending of infections or obtaining diagnostic results for infections. The Administrator explained she thought the process failure was a result of the IP being trained in the spring 2023 and at that time the prior DON was still doing IP duties. She stated when the prior DON left, they thought the new IP new how to do	F 881	of nursing will be responsible for sustained complaince. This will be submitted to QAPI monthly for review. 5. The facility will be in and remain in compliance by: April 5, 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STEWART HEALTH CENTER	6920 MARCHING DUCK DRIVE CHARLOTTE, NC 28210

(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 881	Continued From page 48 infection control, since she had completed the North Carolina State Program for Infection Control and Epidemiology (NC SPICE) training. The Administrator voiced the new IP hesitated to ask questions and this got missed with the DON transition and the facility's focus on transitioning to the new electronic computer system. She stated when the facility was transferring to the new electronic computer system, they were focused on getting everything into the new system and things that should have gotten followed up on were not overseen well. She explained the components of the facility's infection control program not being completed and in place was likely related to the IP being new to the IP role.	F 881		