STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING ______ B. WING ______	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY HEALTH AND REHABILITATION CENTER	**3211 BISHOPS WAY LANE CHARLOTTE, NC 28215**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/07/24 through 10/10/24. The credible allegation was validated on 10/16/24 therefore the exit date was changed to 10/16/24. The faciltiy was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 8T9L11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted on 10/07/24 through 10/10/24. The credible allegation was validated on 10/16/24, therefore the exit date was changed to 10/16/24. The following intakes were investigated: NC00214337, NC00209727, NC00209391, and NC00207818. 7 of the 7 complaint allegations did not result in a deficiency. Immediate Jeopardy was identified at: CFR 483.35 at tag F726 at a scope and severity of J. CFR 483.80 at tag F880 at scope and severity of J. Immediate Jeopardy began on 10/10/24 and was removed on 10/15/24.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to	F 553		11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/08/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 553	Continued From page 1 be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to invite a resident to participate in the planning of the resident's care for 1 of 4 residents reviewed for participation in care plan meetings (Resident # 9). The findings included: Resident #9 was re-admitted to the facility on 9/24/2023.	F 553	1) Resident #9 was invited to his next care plan meeting. The resident's representative was also invited to the care plan meeting. Both invitations were documented in the resident's medical record. This was completed on or before November 8th, 2024, by the resident's assigned social worker. 2) Resident #9 was educated on the care planning process and was updated	

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F 553	Continued From page 2 Review of the electronic medical record for Resident #9 revealed a form dated 7/13/2024, addressed to the family member of Resident #9, notifying them that a care plan meeting needed to be scheduled. Resident #9's most recent minimum data set (MDS) assessment dated 8/7/2024 revealed Resident #9 was cognitively intact with daily decision making and had adequate hearing. Review of the most recent care plan revealed it had been updated in the electronic medical record on 8/27/2024, however there was no indication that there had been any involvement from Resident #9 or family members. Review of the medical record included no evidence that Resident #9 was invited to participate in care plan meetings or evidence of refusing to participate. An interview with Resident #9 completed on 10/8/2024 at 9:54 AM revealed he had not been involved in a care plan meeting and was not aware of what a care plan meeting was. On 10/9/2024 at 2:25 PM an interview with MDS Coordinator #1 revealed care plan meetings were set up by the Social Worker (SW) using the MDS assessment calendar to make sure the care plan meeting dates were aligned with the most recent MDS assessment. The SW would give a list of residents to the receptionist that needed a care plan meeting. The receptionist would then mail out the care plan meeting invitation to the resident's family. Upon receiving the care plan letter the family would call the SW to set up a time to meet. MDS Coordinator #1 stated all	F 553	on the previous care plan meeting's discussions that had occurred with his daughter. Resident #9 was allowed the opportunity for input and questions regarding his plan of care. This was completed on or before November 8th, 2024, by the resident's assigned social worker. 3) The facility's policy and procedure related to the care planning process, resident involvement in the care planning process, how care plan meetings are scheduled, and how resident/resident representatives are invited to the care plan meetings was reviewed and updated. This review and update ensured that the policy and procedure involve residents being invited to the care plan meeting, as well as appropriate documentation showing the resident's invitation to the care plan meeting. The policy and procedure was also updated to include documentation if the resident refuses to, or is unable, to participate in their care planning process. This was completed on or before November 8th, 2024, by the Administrator and facility social workers. 4) Education of the above revised policy and procedure was provided to all parties involved in the scheduling, invitation, and execution of care plan meetings. This was completed on or before November 8th, 2024, by the social workers/designee. 5) An audit will be conducted on all weekly scheduled care plan meetings (prior to the meeting being conducted) to	

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F 553	Continued From page 3 residents, especially ones that were cognitively intact, must be invited to the care plan meetings. On 10/9/2024 at 3:17 PM an interview was completed with SW. The SW explained when Resident #9's care plan meeting was scheduled the family member would be called and care discussed because the resident usually did not want to attend due to difficulty hearing. An additional interview was conducted on 10/10/2024 at 8:44 AM with the facility SW. During the interview the SW reported she usually scheduled care plan meetings on days when Resident #9 could attend. The SW further explained that all residents needed to be invited to the care plan meetings and there should be documentation in the resident electronic medical records if he or she refused to participate. An interview was conducted on 10/10/2024 at 10:54 AM with the Director of Nursing (DON). During the interview the DON reported all residents should be involved in care plan meetings and if the residents chose not to be involved then that should have been documented. The DON went on to say, regardless of cognition the resident needs to be invited. On 10/10/2024 at 2:23 PM and interview was completed with the Administrator where she revealed she expected residents, regardless of cognition, have to be invited to the care plan meetings and if the resident did not want to attend then it needed to be documented in the resident's electronic medical record.	F 553	ensure that those care plan meetings scheduled have the appropriate invitations extended to the resident, when practicable for the resident to attend. Documentation will also be audited to ensure the resident's medical record includes evidence of invitation or refusal. This audit will be conducted once weekly X 4 weeks, then once every two weeks X 2 months, then monthly thereafter, until it is decided by the organization's Quality Assurance Performance Improvement Committee (QAPI) that substantial compliance has been achieved. This will be started, with ongoing audits scheduled, the week of November 4th, 2024, by the social worker's supervisor, MDS nurses, or designee. 6) Audits will be brought to the quarterly QAPI committee meetings. The QAPI committee will review the results of the audit tools quarterly and identify trends, actions taken, and discuss the need for and/or frequency of continued monitoring until substantial compliance is achieved (as determined by the QAPI committee). This will be completed by the administrator, social worker, and interdisciplinary QAPI team on or before November 8th, 2024, with audit reviews with the QAPI committee ongoing (with next QAPI meeting scheduled for January 13th, 2025.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		11/8/24

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F 582	Continued From page 4	F 582		

§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 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

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F 582	Continued From page 5 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 staff interviews and record review, the facility failed to have a Centers for Medicare and Medicaid Services (CMS)-10123 Notice of Medicare Non-Coverage letter (NOMNC) signed prior to discharge from Medicare part A services with benefit days remaining to 1 of 3 residents reviewed for SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review (Resident #307). Findings included: Resident #307 was admitted to the facility under part A Medicare services on 6/19/24. A review of the medical record revealed a NOMNC letter was not signed either physically or verbally by Resident #307 or their responsible party, but was signed by Social Worker #1, with the following statement "Notice waived. Last covered date is 7/2/24 and discharge from the facility on 7/3/24." An interview was conducted with Social Worker	F 582	1) Resident #307 was provided a paper copy of her Medicare Non-Coverage via mail to ensure she received an additional copy of the document. This was completed on or before November 8th, 2024, by the Director of Social Services. 2) All residents with current Medicare Non-Coverage notices in effect (i.e. those who may discharge from Medicare services in the next 48-72 hours) were reviewed to ensure signatures were received on their notices by either the resident (if their own responsible party), or their responsible party. If the resident was unable to sign, and in-person contact was not possible with the responsible party, a telephone conversation was clearly noted on the notice and a paper copy was mailed to the responsible party. All documents were uploaded to the medical record. This was completed on or before November 8th, 2024, by the facility social workers.	

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F 582	Continued From page 6 #1 on 10/10/24 at 11:25 AM revealed she tried to have all the NOMNC forms signed either verbally or in writing but didn't have Resident #307's form signed. She stated Resident #307 wanted to speak to her husband about leaving early as her discharge was near a holiday. Resident #307 discharged a day early due to the holiday. She stated because Resident #307 left early, she signed the notice as "waived" and did not acquire a signature from Resident #307. An interview was conducted with the Administrator on 10/10/24 at 2:26 PM revealed she had the expectation that if a resident could physically sign the NOMNC form, it should be signed but if not a verbal signature from a resident or someone to sign or their behalf was appropriate.	F 582	3) All notices of Medicare Non-Coverage will be issued to the resident (when the resident is their own responsible party) or to their responsible party. Those residents who can sign the notice will do so. In situations where the notification in-person to a responsible party is problematic (when the resident is not competent and the responsible party is unavailable for direct personal contact), the facility will ensure a telephone conversation occurs, with the date clearly noted on the notice. Written notice with the date of the telephone conversation noted will be mailed to the responsible party. A copy of the notice will be placed in the resident's medical file. This was completed on or before November 8th, 2024, with the process ongoing. 4) The facility's policy and procedure related to Medicaid/Medicare coverage and liability notices was reviewed and updated to reflect the process outlined above. This was completed on or before November 8th, 2024, by the Administrator and Director of Health Services. 5) Education was provided to the social workers (and anyone who may issue a Medicare Non-coverage Liability notice) on any facility policy and procedure updates of the Medicaid/Medicare coverage liability notices. This was completed on or before November 8th, 2024, by the Administrator and/or Director of Health Services.	

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F 582	Continued From page 7	F 582	6) Audits will be performed on all weekly Medicare Non-Coverage notices to ensure the facility policy is being followed. This audit will be performed weekly X 4 weeks, once every two weeks X 2 months, and monthly thereafter until it is decided by the organization's Quality Assurance Performance Improvement Committee (QAPI) that substantial compliance has been achieved. This will be started, with ongoing audits scheduled, the week of November 4th, 2024, by the Director of Social Services/designee. 7) Audits will be brought to the quarterly QAPI committee meetings. The QAPI committee will review the results of the audit tools quarterly and identify trends, actions taken, and discuss the need for and/or frequency of continued monitoring until substantial compliance is achieved (as determined by the QAPI committee). This will be completed by the administrator, social worker, and interdisciplinary QAPI team on or before November 8th, 2024, with audit reviews with the QAPI committee ongoing (with next QAPI meeting scheduled for January 13th, 2025.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		11/8/24

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F 636	Continued From page 8 §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive	F 636		

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F 636	Continued From page 9 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (ARD), which was the last day of the assessment period for 1 of 4 residents reviewed for resident assessment (Resident #8). Findings included: Resident #8 was admitted to the facility on 4/17/2018. A review of Resident #8's electronic medical record revealed an annual MDS assessment with an ARD of 9/11/2024 that was open and not signed completed as of 10/09/2024. An interview with MDS Coordinator #1 on 10/09/2024 at 2:59 PM revealed the annual MDS assessment had not been completed and signed within 14 days of the ARD. MDS Coordinator #1 went on to say the assessment had been missed and was being worked on. The MDS Coordinator	F 636	1. The annual assessment of resident #8 was reviewed and completed. This was completed by the MDS nurse on or before October 11th, 2024. 2. Assessments of all residents currently residing at Asbury Health and Rehabilitation were reviewed in comparison with the census to ensure that all residents have future assessments that correlate with the RAI manual. This was completed by the MDS nurse on or before October 21st, 2024. 3. All residents care plans were reviewed to ensure they correlate with the MDS assessments. This was completed by the MDS nurse on or before October 21st, 2024. 4. All interdisciplinary team members will continue to be notified of MDS assessments that are nearing due dates. This communication will be via e-mail on a	

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F 636	Continued From page 10 #1 further explained she and MDS Coordinator #2 had been looking over the assessment schedule to ensure nothing else had been overlooked. On 10/10/2024 at 10:48 AM an interview was completed with the Director of Nursing (DON). During the interview the DON stated the annual MDS assessment for Resident #8 should have been completed within 14 days of the ARD date. The DON went on to say his expectation was that all MDS assessments needed to be completed in the appropriate timeframe. During an interview with the Administrator on 10/10/2024 at 2:23 PM she stated she expected all MDS assessments to be completed in a timely manner.	F 636	weekly basis, as well as via a printed copy supplied to the members completing the MDS assessment, as well as a verbal reminder. This will be completed by the MDS nurse(s) on or before October 21st, 2024, and ongoing. 5. Assessments will be reviewed weekly in correlation to the census to ensure adequate MDS assessment are opened and completed. This was completed by the MDS nurse(s) on or before October 21st, 2024. 6. All assessments will continue to be reviewed weekly by using the census for verification of current residents scheduled by the MDS coordinator. Completed by the MDS nurse(s) on or before October 21st, 2024. 7. There will be random audits of 25% of the Asbury census of their MDS assessments to ensure assessments are signed in the timeframe that correlates with CMS guidelines and RAI manual policies. This audit will be completed weekly X 8 weeks, then monthly thereafter, until it is decided by the organization's Quality Assurance Performance Improvement Committee (QAPI) that substantial compliance has been achieved. This audit will be started, with ongoing audits scheduled, the week of November 4th, 2024. 8. Audits will be brought to the quarterly Quality Assurance Performance Improvement (QAPI) committee meetings	

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F 636	Continued From page 11	F 636	for review and identification of any trends and/or areas of improvement. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. This will be completed by the administrator and interdisciplinary QAPI team on or before November 8th, 2024, with audit reviews with the QAPI committee ongoing (with next QAPI meeting scheduled for January 13th, 2025.	
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		11/8/24

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	345544	A. BUILDING ______ B. WING ______	C 10/16/2024

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implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to have systems in place to ensure Nurse #1 received the most recent training provided by the facility for blood glucose monitors. In addition, Nurse #1 failed to demonstrate competency in following the manufacturer's instructions for the cleaning and disinfection of a shared blood glucose meter between two residents. Nurse #1 stated she knew she was supposed to use the disinfectant wipes to disinfect the blood glucose meters between residents but had just gotten nervous and forgotten. The interview with Nurse #1 further revealed she did not know the wet time, or dry time for cleaning/disinfecting the glucometer using the disinfectant wipe. The deficient practice occurred for 1 of 3 nursing staff reviewed for competent nursing staff (Nurse #1).

Immediate Jeopardy began on 10/10/24 when Nurse #1 failed to demonstrate competency through her failure to disinfect a shared glucometer per manufacturer's instructions. Immediate jeopardy was removed on 10/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more

F 726

1) The nurse found to be non-compliant with the glucometer disinfection process was re-educated with return demonstration immediately, as were all nurses in the building at the time of the observation of non-compliance. This was completed on October 10th, 2024, by the Infection Preventionist, Director of Nursing, and Nursing Supervisor.

2) All nursing staff that do (or could) perform glucose monitoring were in-serviced on the glucometer disinfection process before being allowed to work. All education was completed on or before October 14th, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and/or Nursing Supervisor.

3) All staff members that do (or could) perform glucose monitoring were required to perform a skills validation check to ensure they could perform the disinfection appropriately. Any staff that did not receive the education and perform the skills validation by October 14th, 2024, were not allowed to work until they were

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F 726	Continued From page 13 than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. The findings included: This tag is cross referred to: F880 Based on observation, record review and staff interviews, the facility staff failed to follow the manufacturer's instructions for cleaning and disinfection of a shared blood glucose meter between resident usage for 2 of 4 residents whose blood sugar levels were checked (Resident #95, Resident #207). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were no residents with a bloodborne pathogen in the facility at the time of the investigation. On 10/10/24 at 9:17 AM an interview was conducted with Nurse #1. She stated the facility had a "skills day" in 2023 and she remembered receiving training then about glucometers but since then she had not received any training on glucometers, or disinfecting glucometers. She stated she worked at the facility on a as needed (PRN) basis working one or two days during the week or month and may have just missed training if the facility had conducted one.	F 726	compliant with the educational training. This was completed on or before October 14th, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and/or Nursing Supervisor. 4) All new hires for the nursing team that do (or could) perform glucose monitoring will be educated at hire (with a skills competency performed) on the glucose monitor disinfection process. This was completed on or before October 14th, 2024, and ongoing, by the Assistant Director of Nursing/Staff Development Coordinator, or designee, before the new hire is allowed to take an assignment. 5) All staff will be educated with a skills competency performed on the glucose disinfection process on an annual basis. This will occur annually at the December annual skills fair (or at an annual time determined by nursing leadership). Staff members found to be non-compliant with the annual training will not be allowed to return to work until compliance with education is reached. This will be completed annually by the Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, or designee. This was initiated on or before October 14th, 2024. 6) Audits will be performed on a weekly basis X 3 months to ensure all new hires (that could perform glucose monitoring) have been educated on the glucometer disinfection process. After 3 months, audits will continue on a monthly basis,	

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A glucometer skills check dated October 2023 revealed Nurse #1 received education on glucometer care and disinfecting.

Review of facility documents revealed Nurse #1 attended the annual skills fair in December 2023 and received education on bloodborne pathogens including the modes of transmission and recognizing potential sources of exposure. The training also included decontamination and disinfection of glucometers using disinfectant wipes.

A review of "Blood Glucose Monitors and Control Test" training attendance log, from a training conducted on 05/05/24, revealed Nurse #1 did not receive the education.

An interview was conducted on 10/10/24 at 10:24 AM with the Director of Nursing (DON). The DON stated the Infection Preventionist was constantly providing training and education for staff however Nurse #1 worked on a PRN basis in the facility, and he felt that was why she hadn't received the most recent education regarding glucometers. The interview revealed the IP and SDC always attempted to ensure the PRN staff were receiving education however sometimes staff got overlooked.

An interview was conducted on 10/10/24 at 9:22 AM with the Infection Preventionist. During the interview, the Infection Preventionist stated she had completed a glucometer training course on 05/05/24 for all staff. She stated after reviewing the in-service sheets she had realized Nurse #1 did not receive the training that was conducted. She stated Nurse #1 was, "just missed" because she was an as needed (PRN) staff member.

F 726

indefinitely, to ensure educational compliance. These audits will be performed by the Director of Nursing or designee, on an ongoing basis. The first audit was completed on or before Monday, October 14th, 2024, by the Director of Nursing.

7) Random audits will occur with a selection of 5 nursing team members (who could perform a blood glucose check) to return demonstrate the appropriate glucometer disinfection process. This audit will occur on a weekly basis X 3 months, and then quarterly thereafter, until substantial compliance is observed. This first audit was completed on or before Monday, October 14th, 2024, by the Nursing Supervisor, Assistant Director of Nursing, Director of Nursing, or designee, and ongoing (as outlined) thereafter.

8) Audits of new hires and competencies of existing hires will be brought to the Quality Assurance quarterly meetings for review. The next Quality Assurance meeting was completed on Monday, October 14th, 2024.

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The Staff Development Coordinator (SDC) was not available for an interview.

An interview on 10/10/24 at 2:26 PM with the Administrator revealed the in-service conducted in May 2024 was supposed to be for all staff and Nurse #1 should have received the education. She stated looking back at the education log for Nurse #1 the facility should have ensured she received an updated in-service because Infection Control was a priority for the facility.

The Administrator was notified of immediate jeopardy on 10/10/24 at 3:10 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

A nurse in one of the households, during observation, was found to be non-compliant in following the facility's protocol (and the manufacturer's guidelines) on disinfecting glucometers between resident use. The nurse failed to follow the processes she had been educated on in past trainings, indicating a need to routinely monitor the staff's compliance with the glucometer disinfection policy so that either additional training can be provided, or the deficient practice can be addressed from a performance standpoint. Attendance compliance with important in-service education also needs to be routinely audited, as this nurse missed the last training that was provided on glucometer disinfection.

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All nursing staff that could do a blood glucose monitoring were identified by pulling a log from Human Resources of all applicable nursing staff. This was completed on October 10th, 2024, by the Director of Nursing and the Director of Human Resources.

All residents residing in household two that could have been affected by the deficient practice were seen by the medical provider, with orders received as necessary by the practitioner's assessment. This was completed on October 11th, 2024, by the medical provider on duty.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The nurse found to be non-compliant with the glucometer disinfection process was re-educated with return demonstration immediately, as were all nurses in the building at the time of the observation of non-compliance. This was completed on October 10th, 2024, by the Infection Preventionist, Director of Nursing, and Nursing Supervisor.

All nursing staff that do (or could) perform glucose monitoring will be in-serviced on the glucometer disinfection process before being allowed to work. All education will be completed on or before October 14th, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, or Nursing Supervisor. All staff members will also have a skills validation

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F 726	Continued From page 17 performed to ensure that they can perform the disinfection appropriately. Any staff that do not receive the education and skills validation by the October 14th, 2024, date will not be allowed to work until they are compliant with the educational training. This compliance will be monitored by the Assistant Director of Nursing/Staff Development Coordinator and/or the Infection Preventionist nurse. All new hires for the nursing team that do (or could) perform glucose monitoring will be educated at hire (with a skills competency performed) on the glucose monitor disinfection process. This will be completed by the Assistant Director of Nursing/Staff Development Coordinator, or designee, before the new hire is allowed to take an assignment. All staff will be educated with a skills competency performed on the glucose disinfection process on an annual basis. This will occur annually at the December annual skills fair (or at an annual time determined by nursing leadership). Staff members found to be non-compliant with the annual training will not be allowed to return to work until compliance with education is reached. This will be completed annually by the Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, or designee. Alleged immediate jeopardy removal date: October 15th, 2024 A validation of IJ removal plan was conducted on 10/16/24. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on	F 726		

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F 726	Continued From page 18 the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing. Audits of any newly hired staff were reviewed to ensure they had received education on glucose monitor disinfection. An observation was conducted of glucose disinfection while onsite, the staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers. The IJ removal date of 10/15/2024 was validated.	F 726		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		11/8/24

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F 761	Continued From page 19 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 remove expired medications available for use from the refrigerator of a medication storage room in 1 of 3 medication rooms reviewed for medication storage (Windsor medication room). Findings included: On 10/10/24 at 11:25AM during an observation of the Windsor medication room with Nurse #2 the observation yielded 81 unopened acetaminophen suppositories 650 milligram (mg) with an expiration date of 04/24 (April/2024). On 10/10/24 at 11:28 AM an interview was conducted with Nurse #2. During the interview she stated the refrigerator was checked daily by the nursing staff. She stated she was responsible for checking the medication room refrigerator for the household and had just missed the expiration date by mistake. Nurse #2 stated the mediation had not been used in some time and that was probably why it was missed. The interview revealed the medication was available for nurses to obtain from the room and should have been discarded if it was past the date listed on the packaging.	F 761	1) The medication in question was immediately discarded, with no residents receiving any doses of the medication. This was completed on October 10th, 2024, by the nurse on duty and the Director of Nursing. 2) An audit was performed of all medication storage areas to ensure there were no further expired medications in the building. This was completed on October 10th, 2024, by the Nurse Supervisor, Director of Nursing, and pharmacy consultant. 3) The policy and procedure for medication storage was reviewed and updated, with language reviewed regarding protocols for discarding expired medications. This was completed on or before November 8th, 2024, by the RN Supervisor and Director of Nursing. 4) Education was provided to the nursing staff on the process for checking for expired medication, as well as education surrounding overall medication storage. This was completed on or before November 8th, 2024, by the RN	

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An interview was conducted with the Director of Nursing (DON) on 10/10/24 at 12:35 PM. The DON was informed of the findings in the medication storage room and the DON stated the facility staff had looked in both rooms a couple of days prior and had not found the expired medication. He stated the facility went by the expiration date listed on the packaging of the medication and the expired medications should have been discarded.

An interview was conducted with the Administrator on 10/10/24 at 2:26 PM she stated the medication should have been discarded. She stated she expected nursing staff to check the expiration dates daily.

F 761

Supervisor/designee.

5) Weekly audits will be performed on all medication storage areas by the nurses/medication aides on duty to ensure compliance with medication expiration dates. This will be completed on or before November 8th, 2024, and ongoing, by the nurses on duty.

6) Random audits of 10 medication storage areas will be performed weekly X 4 weeks, then once every two weeks, and then monthly thereafter until it is decided by the organization's Quality Assurance Performance Improvement Committee (QAPI) that substantial compliance has been achieved. This will be started, with ongoing audits scheduled, the week of November 4th, 2024, by the Director of Nursing/designee.

7) Audits will be brought to the quarterly QAPI committee meetings. The QAPI committee will review the results of the audit tools quarterly and identify trends, actions taken, and discuss the need for and/or frequency of continued monitoring until substantial compliance is achieved (as determined by the QAPI committee). This will be completed by the Director of Nursing, RN Supervisors, pharmacy consultant, and interdisciplinary QAPI team on or before November 8th, 2024, with audit reviews with the QAPI committee ongoing (with next QAPI meeting scheduled for January 13th, 2025.

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 record review, observations and staff interviews, the facility failed to label and date leftover food items stored for use in the dry goods storage area and walk-in cooler and failed to ensure residents' leftover food items stored in nourishment room refrigerators were labeled and dated for 2 of 6 common area refrigerators (400 and 300 Hall nourishment rooms). These practices had the potential to affect food served to residents. The findings included: 1. An initial tour of the dry good storage area and walk-in cooler occurred on 10/7/24 at 11:30 AM	F 812	1) All items identified as unlabeled and/or expired during the survey observation were immediately discarded (items from the dry goods and walk-in cooler and resident items found in the resident refrigerators of the 300 and 400 households). Completed on or before October 9th, 2024, by the Director of Culinary, Executive Chef, and Culinary Supervisor. 2) 100% audit of culinary freezers, refrigerators, and dry storage to ensure no items were opened without dates, and/or expired. No expired or unlabeled items	11/8/24

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with the Executive Chef. The dry goods storage and walk in refrigerator were in the basement and served all neighborhoods in the facility. The following concerns were identified:
-a bag of bowtie pasta opened 4/4/24 with a use by date of 7/4/24 stored in the dry good storage area
-a metal pan of pork butt prepared 9/29/24 with a use by date of 10/3/24 stored in the walk-in cooler

An interview with the Executive Chef on 10/7/24 at 11:35 AM revealed staff went through the walk-in cooler, walk-in freezer, and dry goods storage on Mondays to clean out any food items past the use by date and they had not been to the storage area yet that day.

2. A tour of the resident common area refrigerators occurred on 10/9/24 at 12:35 PM. The following concerns were identified:

a. Items in the 400-hall resident refrigerator opened and not labeled with a date or room number were a 46fl oz. bottle of vegetable juice and a half of an ice cream sheet cake in freezer.

b. Items in the 300-hall resident refrigerator labeled "305" but with no date or name included two cartons of pre-hardboiled eggs which had a strong, foul odor, eight pears in carboard cartons, six apples in bags, six frozen meals, and a 16fl oz. container of coffee ice cream. A 16oz. carton of heavy whipping cream was stored past the expiration date.

An interview with the Dietary Manager (DM) on 10/9/24 at 3:29 PM revealed the items in the resident common area refrigerators needed to be labeled with the name of the resident and their

F 812

were present. Completed by the Director of Culinary and the Executive Chef on or before October 16th, 2024.

3) In-service of all dietary staff communicating that it is their responsibility to ensure open food and drinks in culinary refrigerators and freezers, as well as resident refrigerators and freezers, are dated and that any out-of-date food and drinks are discarded. This in-service was performed using the Label and Dating Guidelines from the USDA, with visual examples of proper labeling and dating. The culinary team was also educated on the monitoring tool used and frequency of monitoring that will occur. This in-service was completed on or before October 16th, 2024, after which time, no culinary staff will be allowed to work until they complete the in-service.

4) This above-mentioned in-service will be part of the orientation process for all newly hired dietary employees. Completed by the Director of Culinary/designee on or before October 16th, 2024.

5) Updates were made to the Outside Food Policy distributed as part of the residents' admission paperwork that included updated guidelines on labelling and dating food items stored in resident refrigerators. These guidelines were also posted on all resident refrigerators in each household. These updates were conducted on or before October 25th, 2024, by the Director of

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room number. She explained there was no timeline for the use by date and the facility went by the expiration date on the item. The DM stated dietary supervisors checked the refrigerators each morning to ensure there were no items in the refrigerators out of date.

An interview with the Administrator on 10/10/24 at 2:36 PM revealed she had the expectation that stored food should be properly labeled and dated in the facility's refrigerators and storage rooms. The Administrator stated that food left in the resident refrigerators should be thrown out if they were past the expiration date.

F 812

Culinary/designee.

6) An in-service was held for all nursing staff to inform them of the updated policy, which includes that all labels must include the following: The resident name, resident room number, the name/description of the item, and the date it was placed in the refrigerator. The culinary team was trained that any item without a manufacturer's expiration date should be discarded after 72 hours/3 days from the date of storage. The culinary team was also trained that any item that is either unlabeled, or the label does not meet the above outlined criteria, should be discarded immediately. These trainings were conducted on or before October 25th, 2024, by the Director of Culinary/designee.

7) The following on-going monitoring procedures will be conducted to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

100% audit of facility food storage areas, including freezers, will be conducted 5 times weekly x 4 weeks, and then 3 times weekly ongoing, ensuring open food and/or drinks are dated and are not expired. The progress and results of said audits will be reviewed once weekly by the Executive Chef and once monthly by the Director of Culinary. This was completed by the Executive Chef, Sous Chef, Director of Culinary, and/or designee on or before October 16th, 2024, and

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F 812	Continued From page 24	F 812	ongoing. 8) Audits of all refrigerators/freezers including culinary refrigerators and the resident refrigerators/freezers in the household communal areas will be reviewed weekly by the Executive Chef and monthly by the Culinary Director. These audits will be shared monthly with the Administrator and Executive Director for active monitoring. This will be completed on or before October 16th, 2024, and ongoing, by the Executive Chef and Culinary Director with the Administrator and Executive Director. 9) Audits will be brought to the quarterly QAPI committee meetings. The QAPI committee will review the results of the audit tools quarterly and identify trends, actions taken, and discuss the need for and/or frequency of continued monitoring until substantial compliance is achieved (as determined by the QAPI committee). This will be completed by Director of Culinary and interdisciplinary QAPI team on or before November 8th, 2024, with audit reviews with the QAPI committee ongoing (with next QAPI meeting scheduled for January 13th, 2025).	
F 880 SS=J	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	F 880		11/8/24

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F 880	Continued From page 25 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 §483.71 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: (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	F 880		

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F 880	Continued From page 26 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 observations, record review and staff interviews, the facility staff failed to follow the manufacturer's instructions for cleaning and disinfection of a shared blood glucose meter between resident usage for 2 of 4 residents whose blood sugar levels were checked (Resident #95, Resident #207). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were no residents with a bloodborne pathogen in the facility at the time of the investigation.	F 880	1) All residents residing in the household where the deficient practice was identified that could have been affected by the deficient practice were seen by the medical provider, with orders received as necessary by the practitioner's assessment. This was completed on October 11th, 2024, by the medical provider on duty. 2) All glucometers in the building were disinfected immediately, per policy and manufacturer's recommendations. This was completed on October 10th, 2024, by the nursing supervisor and nurses on duty. 3) The Mecklenburg County	

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Immediate Jeopardy began on 10/10/24 when Nurse #1 was observed performing blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's instructions. Immediate jeopardy was removed on 10/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place.

Findings included:

The blood glucose meter manufacturer's instructions for cleaning and disinfecting dated 04/2023 indicated the blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. A list of Environmental Protection Agency (EPA) wipes were recommended on the cleaning instructions. Additional instructions were to read the manufacturer's instructions for the use of the wipes.

Review of the facility policy "Glucometer Disinfection" revised in May 2024 read, in part, to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The procedure for disinfecting glucometers included:
a. Obtain needed equipment and supplies:

F 880

Communicable Disease branch was notified of the infection control breach. An update was also provided to the division on the plan in place for correction. Communication was also provided to the residents affected by the deficient practice and/or their responsible parties. Communication to the local health department and the residents/responsible parties completed on October 11th, 2024, by the Executive Director (health department communication) and the Assistant Director of Nursing/Staff Development Coordinator (resident and responsible party notifications).

4) All diagnoses of residents in the building were reviewed to ensure that no one currently has an active diagnosis of a bloodborne pathogen. This was completed on October 10th, 2024, by the Infection Preventionist and Administrator.

5) The policy and procedure for glucometer disinfection was reviewed and compared to manufacturer recommendations. This was completed on October 10th, 2024, by the Infection Preventionist and Administrator.

6) The nurse found to be non-compliant with the glucometer disinfection process was re-educated with return demonstration immediately, as were all nurses in the building at the time of the observation of non-compliance. This was completed on October 10th, 2024, by the Infection Preventionist, Director of Nursing, and Nursing Supervisor.

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Gloves, glucometer, alcohol pads, gauze pads, single use lancet, blood glucose testing strips, disinfecting wipes.
b. Wash hands
c. Explain the procedure to the resident.
d. Provide privacy.
e. Put on gloves.
f. Obtain capillary blood glucose sampling according to the facility policy.
g. Remove and discard gloves, perform hand hygiene prior to exiting room.
h. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive.
i. Retrieve (2) disinfectant wipes from container.
j. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer.
k. After cleaning, use a second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturers' instructions. Allow the glucometer to dry air.
l. Discards disinfect wipes in waste receptacles.
m. Perform hand hygiene.

The wipes container which was located at the nurses station read in part to disinfect nonfood contact surfaces to thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for bloodborne pathogen use.

A continuous observation of Nurse #1 was conducted from 10/10/24 at 8:54 AM through 9:17 AM and revealed the following:
On 10/10/24 at 8:54 AM Nurse #1 gathered necessary supplies, removed the glucometer from the top of the cart and went into Resident

F 880

7) All nursing staff that do (or could) perform glucose monitoring were in-serviced on the glucometer disinfection process before being allowed to work. All education was completed on or before October 14th, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and/or Nursing Supervisor.

8) All staff members that do (or could) perform glucose monitoring were required to perform a skills validation check to ensure they could perform the disinfection appropriately. Any staff that did not receive the education and perform the skills validation by October 14th, 2024, were not allowed to work until they were compliant with the educational training. This was completed on or before October 14th, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, and/or Nursing Supervisor.

9) All new hires for the nursing team that do (or could) perform glucose monitoring will be educated at hire (with a skills competency performed) on the glucose monitor disinfection process. This was completed on or before October 14th, 2024, and ongoing, by the Assistant Director of Nursing/Staff Development Coordinator, or designee, before the new hire is allowed to take an assignment.

10) All staff will be educated with a skills competency performed on the glucose disinfection process on an annual basis.

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#95's room and obtained his blood sugar. She exited the room at 9:04 AM and returned to the cart in the hall. Nurse #1 was observed placing the glucometer immediately back into the unlabeled black bag on the cart and move to the next room. No disinfecting wipes were observed on the medication cart. Nurse #1 did not disinfect the glucometer during the observation.

At 9:06 AM Nurse 1 gathered necessary supplies, removed the same glucometer from the top of the cart and went into Resident #207's room and obtained her blood sugar. She exited the room at 9:10 AM and returned to the cart in the hall. Nurse #1 was observed placing the glucometer immediately back into the unlabeled black bag on the cart and move to the next resident room. Nurse #1 did not disinfect the glucometer during the observation.

At 9:13 AM of Nurse #1 necessary supplies, removed the same glucometer from the top of the cart and went into Resident #49's room. The surveyor stopped Nurse #1 and asked her to return to the hallway.

An interview and observation occurred with Nurse #1 on 10/10/24 at 9:17 AM. Nurse #1 revealed she had worked in the facility for 9 years as an as needed (PRN) nurse and she knew she was supposed to disinfect the glucometer after each use. Nurse #1 was observed cleaning the glucometer with an alcohol swab.

At 9:17 AM Nurse #1 re-entered Resident #49s room to obtain his blood sugar. The surveyor stopped Nurse #1 for the second time. Nurse #1 exited Resident #49's room and entered the hallway. Nurse #1 stated she knew she was

F 880

This will occur annually at the December annual skills fair (or at an annual time determined by nursing leadership). Staff members found to be non-compliant with the annual training will not be allowed to return to work until compliance with education is reached. This will be completed annually by the Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, or designee. This was initiated on or before October 14th, 2024.

11) Audits will be performed on a weekly basis X 3 months to ensure all new hires (that could perform glucose monitoring) have been educated on the glucometer disinfection process. After 3 months, audits will continue on a monthly basis, indefinitely, to ensure educational compliance. These audits will be performed by the Director of Nursing or designee, on an ongoing basis. The first audit was completed on or before Monday, October 14th, 2024, by the Director of Nursing.

12) Audits will occur with a selection of 5 nursing team members (who could perform a blood glucose check as part of their job duties) to return demonstrate the appropriate glucometer disinfection process. These nurses will be selected based off the staff schedule for the timeframe the audit is being performed. This audit will occur on a weekly basis X 3 months, and then quarterly thereafter, until substantial compliance is observed. This first audit was completed on or

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F 880	Continued From page 30 supposed to use the disinfectant wipes but had just gotten nervous and forgotten. She stated she did not know the wet time, or dry time for cleaning the glucometer using the disinfectant wipe. The interview revealed she typically cleaned the glucometer in between residents and had been instructed to do so in the past. An interview on 10/10/24 at 9:22 AM with the Infection Preventionist (IP) revealed each resident household had 2 glucometers to use because not all residents admitted into the facility had their own glucometer. She stated the facility was very strict on disinfecting glucometers in between use of each resident and had just provided education on glucometer cleaning and disinfecting in May 2024. The IP stated the nurses should be using the disinfectant wipes after each use of the glucometer with a wet contact time of 2 minutes using two wipes and wiping the entire surface of the glucometer. After that, the nurses are to lay the glucometer on a towel and let it dry for a duration of 2 minutes. The IP stated she had contacted the Center for Disease Control and Prevention (CDC) to ensure it was okay to use the glucometer on multiple residents. She was told the practice was acceptable if the glucometer was disinfected per the manufacturer's instructions in between each resident use. The IP indicated Nurse #1 had not received the recent training on disinfecting glucometers in May 2024. She stated Nurse #1 should have known the policy on cleaning the glucometers and followed it. The interview further revealed the use of an alcohol swab to disinfect the glucometer was not an acceptable practice. The IP stated the negative outcome that could occur from not disinfecting the glucometer between resident use included the spread of	F 880	before Monday, October 14th, 2024, by the Nursing Supervisor, Assistant Director of Nursing, Director of Nursing, or designee, and ongoing (as outlined) thereafter. 13) Audits of new hires and competencies of existing hires will be brought to the Quality Assurance quarterly meetings for review. The next Quality Assurance meeting was completed on Monday, October 14th, 2024.	

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bloodborne pathogens. She stated there were no current residents in the facility with a bloodborne pathogen. The IP stated the facility did not have dedicated glucometers to each individual resident because the staff had been provided with education and training on how to disinfect the glucometers per manufacturer's instructions. She stated Nurse #1 had not been included in the recent education. The interview revealed the household observed had a total of two glucometers and Nurse #1 should have been utilizing both.
An interview was conducted on 10/10/24 at 10:24 AM with the Director of Nursing (DON). The DON stated that the disinfecting contact time for the blood glucose meter should be two minutes. He stated the staff had been trained and he did not know why Nurse #1 didn't follow policy. The DON stated he had worked in the facility since August 2024 and the process of using a glucometer for multiple residents had not been an issue because the facility had provided education to the staff.

An interview on 10/10/24 at 2:26 PM with the Administrator revealed that blood glucose meters should be disinfected according to the manufacturer's instructions.

The Administrator was notified of immediate jeopardy on 10/10/24 at 3:10 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

A nurse (Nurse #1) in one of the households,

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F 880	Continued From page 32 during observation, was found to be non-compliant in following the facility's protocol (and the manufacturer's guidelines) on disinfecting glucometers between resident use. All residents residing in the building that receive blood glucose monitoring at the time of the observation of non-compliance were identified, especially those that resided in the same household where the non-compliance occurred. These residents were identified immediately after notification of the deficient practice observation, on October 10, 2024, by the Infection Preventionist and MDS nurse. All residents residing in household two that could have been affected by the deficient practice were seen by the medical provider, with orders received as necessary by the practitioner's assessment. This was completed on October 11, 2024, by the medical provider on duty. All glucometers (12 in total) that are presently in the clinical spaces in the building were disinfected immediately, per policy and manufacturer's recommendations. The brand of wipes used are McKesson Disposable Germicidal Surface wipes. This disinfection is completed by using one wipe to wipe away any visibly soiled areas of the glucometer. Using a second wipe, the glucometer is wiped down again to disinfect, followed by two minutes of air-dry time. This was completed on October 10, 2024, by the nursing supervisor and nurses on duty All diagnoses of residents in the building were reviewed to ensure that no one currently has an active diagnosis of a bloodborne pathogen. This	F 880		

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F 880	Continued From page 33 was completed on October 10, 2024, by the Infection Preventionist and Administrator. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The policy and procedure for glucometer disinfection was reviewed and compared to manufacturer recommendations. This was completed on October 10, 2024, by the Infection Preventionist and Administrator. The nurse found to be non-compliant with the glucometer disinfection process was re-educated with return demonstration immediately, as were all nurses in the building at the time of the observation of non-compliance. This was completed on October 10, 2024, by the Infection Preventionist, Director of Nursing, and Nursing Supervisor. All nursing staff that do (or could) perform glucose monitoring will be in-serviced on the glucometer disinfection process before being allowed to work. All education will be completed on or before October 14, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, or Nursing Supervisor. All staff members will also have a skills validation performed to ensure that they can perform the disinfection appropriately. Any staff that do not receive the education and skills validation by October 14, 2024, date will not be allowed to work until they are compliant with the educational training. This compliance will be monitored by the Assistant Director of Nursing/Staff Development Coordinator and/or the Infection Preventionist nurse.	F 880		

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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 880	Continued From page 34 The Mecklenburg County Communicable Disease branch was notified of the infection control breach. An update was also provided to the division on the plan in place for correction. Communication was also provided to the residents affected by the deficient practice and/or their responsible parties. Communication to the local health department and the residents/responsible parties completed on October 11, 2024, by the Executive Director (health department communication) and the Assistant Director of Nursing/Staff Development Coordinator (resident and responsible party notifications). Immediate jeopardy removal date of October 15, 2024. A validation of IJ removal plan was conducted on 10/16/24. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing. Audits of any newly hired staff were reviewed to ensure they had received education on glucose monitor disinfection. An observation was conducted of glucose disinfection while onsite, the staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING ______ B. WING ______	C 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY HEALTH AND REHABILITATION CENTER	**3211 BISHOPS WAY LANE** **CHARLOTTE, NC 28215**

(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 880	Continued From page 35 The IJ removal date of 10/15/2024 was validated.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345544	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 10/16/2024
NAME OF PROVIDER OR SUPPLIER **ASBURY HEALTH AND REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **3211 BISHOPS WAY LANE CHARLOTTE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 640

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 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 a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 3 sampled residents (Resident #303).

The findings included:

Resident #303 was admitted to the facility on 10/27/23.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345544	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 10/16/2024
NAME OF PROVIDER OR SUPPLIER **ASBURY HEALTH AND REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **3211 BISHOPS WAY LANE CHARLOTTE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1

A review of a nursing progress note dated 11/10/2023 at 12:41 PM revealed, in part, Resident #303 was discharged to a hospice house. Discharge instructions were explained to Resident #303 and her family. All of Resident #303's belongings were moved out of her room at the time of discharge.

Further review of Resident #303's medical record revealed that the MDS discharge assessment was not completed until 12/5/23.

On 10/9/24 at 2:59 PM, an interview occurred with the MDS Nurse. She revealed Resident #303's discharge assessment was not completed until 12/5/23. She stated the assessment should have been completed before 12/5/23 and should have been signed within 14 days of the assessment being opened on 11/10/23. The MDS Coordinator explained the discharge assessment was completed within the timeframe, but not signed as complete until 12/5/23.

An interview with the Director of Nursing (DON) on 10/10/24 at 2:05 PM revealed he expected the discharge assessments to be completed in the correct timeframe.

During an interview with the Administrator on 10/10/2024 at 2:23 PM she stated she expected all MDS assessments to be completed in a timely manner.