STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING ______ B. WING ______	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	**2300 ABERDEEN BOULEVARD GASTONIA, NC 28054**

(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 from 10/28/2024 through 10/31/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FC9S11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 10/28/2024 through 10/31/2024. Event ID # FC9S11.	F 000		
F 583 SS=D	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 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.	F 583		11/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/22/2024

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 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(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 observation, record review, Guardian, Podiatrist, and staff interviews, the facility failed to provide personal privacy for Resident #28 when the Podiatrist cut her toenails in the facility's day room visible to other residents. This deficient practice was for 1 of 1 resident reviewed for personal privacy (Resident #28). The findings included: Resident #28 was admitted to the facility on 7/25/22 with diagnoses that included dementia with mood disturbance and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated 9/30/24 revealed that Resident #28 was severely cognitively impaired and exhibited no behaviors or rejections of care during the assessment period. An observation conducted in the facility's day room on 10/30/24 at 12:00 PM revealed there were 10 residents seated at tables around the room. Resident #28 sat in her wheelchair in the center of the room and the Podiatrist sat on the floor in front of her and cut her toenails. There was no privacy curtain or shield in place around	F 583	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. · Licensed staff, including the CNA and Nurse were educated on 10/30/2024 immediately after discovering breach of privacy. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice · Current Residents are at risk	

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F 583	Continued From page 2 Resident #28. Nurse Aide (NA) #1 knelt beside Resident #28 and held her hand. An interview was conducted with NA #1 on 10/30/24 at 2:10 PM. NA #1 indicated when she was assigned to make rounds with the Podiatrist, they went to the residents' rooms to provide foot care. NA #1 revealed on 10/30/24 Resident #28 was in the day room with other residents. She stated she went into the day room with the Podiatrist, and he cut Resident #28's toenails. NA #1 indicated the Podiatrist was not concerned that there were other residents in the room, so she did not think it was an issue. NA #1 revealed that she should have taken Resident #28 to her room or a private area to have her toenails cut. A phone interview was conducted with the Podiatrist on 10/30/24 at 3:30 PM. He indicated that he had been providing podiatry services to the facility for 2 years. He stated during his scheduled visits he made rounds with a staff member and provided foot care in the residents' rooms. The Podiatrist revealed on 10/30/24 NA #1 brought him to the day room where Resident #28 was sitting with other residents. He stated NA #1 did not offer to take Resident #28 to her room, so he "tried to be discreet" and cut Resident #28's toenails in the day room. The Podiatrist further stated he preferred residents to be in a private area that was not visible to others when he provided foot care. A telephone interview was conducted with Resident #28's Guardian on 10/31/24 at 9:23 AM. She revealed that Resident #28 had always taken pride in her appearance and was "very put together" when she went out in public. She stated that Resident #28 would not have wanted	F 583	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. · Current Licensed staff was educated on resident rights including the right to personal privacy while receiving care. This education was completed on 11/21/2024 by Staff Development Coordinator. · No licensed staff will be able to work until education has been completed. · All new hires will be educated on resident rights including personal privacy while receiving care during the orientation process. · Medical professionals educated on resident rights including personal privacy via facility newsletter by the facility medical director on 10/30/2024. · New medical professionals will be educated on resident rights including personal privacy by the facility medical director prior to taking assignment in the facility. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting · The director of nursing or designee will audit 3 resident interactions for personal	

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F 583	Continued From page 3 to receive foot care in an area that was visible to others. The Guardian further stated if Resident #28 was cognitively intact and able to communicate her needs she would have requested to go to her room or a private area to have her toenails cut. An interview was conducted with the Director of Nursing (DON) on 10/30/24 at 2:00 PM. The DON indicated that the facility contracted with an outside company to provide podiatry services. She revealed a staff member was assigned to make rounds with the Podiatrist on the day he was scheduled to visit, and he provided foot care in the residents' rooms. She stated NA #1 was assigned to make rounds with the Podiatrist on 10/30/24. The DON revealed that she was aware Resident #28 received foot care in the day room, visible to other residents. She stated the Podiatrist and NA #1 should have taken Resident #28 to her room to cut her toenails. The DON indicated resident foot care should be provided in a private area that was not visible to others. An interview was conducted with the Administrator on 10/31/24 at 1:07 PM. She stated the facility had a contract with an outside company that provided podiatry services to the residents. She revealed on the day the Podiatrist was scheduled to visit he made rounds with an assigned staff member and foot care was provided in the residents' rooms. The Administrator indicated she was aware that the Podiatrist cut Resident #28's toenails in the day room visible to other residents. She stated Resident #28 should have been taken to her room or a private area to have her toenails cut.	F 583	privacy during patients care. Audits will be 5x weekly x4 weeks, 3x weekly x4 weeks, 1xweekly x4 weeks. 5. Results will be reported by the Director of Nursing to the quality assurance meeting x1 month for further resolution as needed.	