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 _____	C 07/09/2021

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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 and complaint investigation were conducted on 07/06/21 through 07/09/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MWJU11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation were conducted on 07/06/21 through 07/09/21. One allegation was investigated and unsubstantiated. Event ID# MWJU11.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		8/6/21

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

Electronically Signed | 08/02/2021

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F 585	Continued From page 1 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 585		

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F 585	Continued From page 2 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a grievance policy that included: the residents' right to receive a written summary of the grievance resolution, the name and contact information of the designated grievance official and the contact information of independent entities with whom grievances may	F 585	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	

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F 585	Continued From page 3 also be filed such as pertinent State agency, State Long Term Care Ombudsman or Quality Improvement Organization. Findings included: Review of the facility's grievance policy, with a revised date of 11/04/17 and provided by the Administrator, specified in part the facility would provide residents, resident's responsible party or representatives an opportunity for resolution of a concern, complaint, grievance, or ethical issue that may arise during a resident's stay without fear of reprisal in any form. Further review revealed the grievance policy did not include the name, business address or email of the Grievance Official or the contact information of independent entities with whom grievances may also be filed. In addition, the grievance policy specified a written response of the grievance resolution would be provided to the resident or responsible party upon request. During an interview on 07/08/21 at 5:25 PM, the Administrator explained residents, or their responsible party, did not receive a copy of the grievance resolution unless requested. She confirmed the grievance policy, with a revised date of 11/04/17 and review date of 05/2020, was the most current policy. The Administrator was not familiar with the federal regulation related to grievances and acknowledged the facility's current grievance policy did not contain all the required components as outlined in the regulation and would need to be updated.	F 585	regulations, the facility has taker or will take the actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be completed by the dates indicated. The facility maintains a Quality Assurance and Performance Improvement Committee that meets monthly to identify issues with respect to which quality assurance activities are necessary, develop and implement appropriate plans of action to correct identified quality deficiencies. 1. Corrective action for resident(s) affected by the alleged deficient practice. There were no specific residents identified in the SOD. The Grievance policy will be updated to reflect the Regulatory requirements in F585. 2.Corrective action for the residents with the potential to be affected by the alleged practice. There were no specific residents identified in the SOD. 3.Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Revision and Education: The Grievance Policy and the Grievance form have been updated to reflect regulatory requirements. Staff was educated on 07/22/21 by the NHA and the SDC in a Town Hall meeting on the new policy and the new grievance form. The facility has also updated the resident information boards showing the name and	

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F 585	Continued From page 4	F 585	contact information for the facility Grievance officer and the contact information of the independent entities with whom grievances may be filed. 4.Monitoring Procedure to ensure the plan of correction is effective and that that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. Social Services Grievance Officer will audit grievances each week x 4 weeks and then monthly x 3 months to ensure that a written response summary of the grievance resolution has been completed and provided to the resident. These findings will be reviewed at the QAPI meetings. POC will be fully completed by 08/06/2021	
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 record review, observations, and staff interviews the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of restraints (Resident #6), pressure ulcers (Resident #33), falls (Resident #33, #175), and for the use of a non-invasive mechanical ventilator (Resident#49) for 4 of 20 residents reviewed for accuracy. The findings included:	F 641	1.Corrective action for resident(s) affected by the alleged deficient practice. Corrections have been completed and submitted for the alleged deficient practice on the four (4) identified residents. 2.Corrective action for the residents with the potential to be affected by the alleged practice. MDS coordinator will review all current	8/6/21

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F 641	Continued From page 5 1. Resident #6 was admitted to the facility on 9/30/20 with diagnoses which included vascular dementia and major depressive disorder. Review of the quarterly MDS dated 4/3/21 for physical restraints used in bed revealed a restraint identified as other was used less than daily. Observations revealed on 7/8/21 at 10:31 AM revealed Resident #6 sitting upright in a wheelchair covered with a blanket. A second observation on 7/8/21 at 2:32 PM revealed Resident #6 resting in bed. There were no bed rails in place. The bed was low to the floor with 1 side against the wall. An interview conducted on 7/08/21 at 3:43 PM with the Physical Therapist (PT) revealed she worked at the facility for approximately 2 years and stated it was restraint free. The facility didn't use wrist or lap boards, quarter, or full-length bed rails, or bed and chair alarms. During an interview on 7/9/21 at 2:46 PM MDS Coordinator #1 explained it was an error to code Resident #6's quarterly MDS for the use of physical restraints. MDS Coordinator #1 explained the facility didn't use restraints. During an interview the on 7/9/21 at 6:10 PM the Administrator confirmed the facility didn't use restraints and the quarterly MDS dated 4/3/21 for Resident #6 was inaccurate. The Administrator indicated a modification would be done to reflect restraints weren't used for Resident #6. 2. a. Resident #33 was admitted to the facility on	F 641	residents that have the potential to be affected by the alleged deficient practice. 3.Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: NHA in-serviced the MDS Coordinator and MDS assessment nurse on the importance of accurate coding on the Minimum Assessment Data Set to ensure the assessment accurately reflects the resident□s status. Completed 07/29/2021. NHA/DON/MDS RN/designee will conduct an audit of a minimum of 20 active MDS's during the week of 08/2/21-08/06/21 to determine if other coding issues are present for restraints, pressure ulcers, falls or non-invasive mechanical ventilators to ensure accuracy of coding. Thereafter, the Director of Nursing/designee will review a minimum of 6 MDS□s weekly for 4 weeks and then 6 MDS's every other week for 4 weeks, and then 6 MDS's monthly for 2 months, prior to file submissions to validate accuracy of coding related to the alleged deficiencies. MDS nurse and MDS Assessment Nurse may reach out to the Clinical Consultant Group for any questions or concerns about coding accuracy. Either the MDS Coordinator or the MDS Assessment Nurse will begin to attend the weekly "At-Risk" meetings to gather and utilize resident data to help with the coding accuracy of the resident data. Completed 07/30/21. 4.Monitoring Procedure to ensure the plan	

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F 641	Continued From page 6 1/5/21. Diagnoses for Resident #33 included displaced fracture of right femur with routine healing and Alzheimer's disease. A wound evaluation and management summary dated 3/11/21 identified a stage 3 pressure wound of the right heel. Based on the evaluation the duration of the wound was greater than 19 days measuring 0.5 centimeters (cm) in length and 3 cm in width and 0.1 cm in depth and had improved. Review of the quarterly MDS dated 3/13/21 assessed Resident #33 as having no unhealed pressure ulcers. The skin and ulcer/injury treatments included a pressure reducing device for the bed and chair and applications of ointments and/or medications. During an interview on 7/9/21 at 2:44 PM MDS Coordinator #1 revealed the quarterly MDS dated 3/13/21 should've coded the presence of an unhealed pressure ulcer based on the wound evaluation dated 3/11/21. MDS Coordinator #1 revealed the quarterly MDS dated 3/13/21 was inaccurate for pressure ulcer and was a coding error. An interview was conducted on 7/9/21 at 5:42 PM with the Administrator. The Administrator confirmed the quarterly MDS dated 3/11/21 was coded inaccurately and explained during weekly meetings residents at risk were discussed for wound care and pressure ulcers. The MDS Coordinators currently didn't attend those meetings but it would be good for them to start to ensure they were aware of residents with wounds.	F 641	of correction is effective and that that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. The Director of Nursing/designee will review a minimum of 6 MDS□s weekly for 4 weeks and then 6 MDS's every other week for 4 weeks, and then 6 MDS's monthly for 2 months, prior to file submissions to validate accuracy of coding related to the alleged deficiencies. The results of the audits will be reviewed at the QAPI meetings for improvements and/or trends and the plan will be adjusted based on the data. *Completion date no later than 8/6/2021	

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F 641	Continued From page 7	F 641		

2. b. Resident #33 was admitted to the facility on 1/5/21. Diagnoses for Resident #33 included displaced fracture of right femur with routine healing and Alzheimer's disease.

A review of the incident report dated 3/30/21 revealed Resident #33 had a witnessed fall when attempting to stand unassisted and step over the leg rest of the wheelchair. The incident report explained Resident #33 fell to the floor landing on her left side.

The quarterly MDS dated 5/13/21 was coded as there had been no falls since the previous assessment. The previous MDS assessment was a quarterly dated 3/13/21.

During an interview on 7/9/21 at 2:49 PM MDS Coordinator #1 explained not coding a fall occurred was an error; therefore, the MDS was inaccurate.

During an interview on 7/9/21 at 5:47 PM the Administrator confirmed the MDS should reflect a fall occurred. The Administrator explained the MDS Coordinator was new to the position and more training would be done to help clarify how to document falls on the MDS.

3. Resident #175 was admitted to the facility on 6/24/21 with diagnoses which included traumatic subdural hemorrhage and unspecified fall.

Review of the incident report dated 6/26/21 revealed Resident #175 was observed on floor in her room.

The admission MDS dated 6/28/21 was coded as there had been no falls since Resident #175's

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F 641	Continued From page 8	F 641		

admission to the facility.

During an interview on 7/9/21 at 2:49 PM MDS Coordinator #1 explained not coding a fall occurred was an error; therefore, the MDS was inaccurate.

During an interview on 7/9/21 at 5:47 PM the Administrator confirmed the MDS should reflect a fall occurred. The Administrator explained the MDS Coordinator was new to the position and more training would be done to help clarify how to document falls on the MDS.

4. Resident #49 was admitted to the facility 06/01/21 with diagnoses that included diabetes, emphysema (lung condition that causes shortness of breath) and pneumonia.

The admission Minimum Data Set (MDS) dated 06/05/21 assessed Resident #49 with severe cognitive impairment. The MDS noted he used a BiPAP (Bilateral Positive Airway Pressure)/CPAP (Continuous Positive Airway Pressure) (type of devices that help with breathing) while a resident.

An observation conducted on 07/08/21 at 8:38 AM of Resident #49's room revealed no evidence of a CPAP or BiPAP device.

During an interview on 07/09/21 at 1:11 PM, MDS Coordinator #2 confirmed she coded Section O, Special Treatment on the admission MDS dated 06/05/21 for Resident #49. MDS Coordinator #2 explained she had coded use of BiPAP/CPAP for Resident #49 based on the hospital discharge summary which noted he used it at bedtime. She verified Resident #49 did not have a BiPAP/CPAP

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F 641	Continued From page 9 in his room and there was no physician order for use of BiPAP/CPAP device or evidence he had used one since his admission to the facility. MDS Coordinator #2 stated Resident #49's use of a BiPAP/CPAP while a resident was incorrectly coded on the MDS assessment dated 06/05/21 and a modification would be submitted. During an interview on 07/09/21 at 5:38 PM, the Administrator explained MDS Coordinator #2 was new to the position and just made an error coding Resident 49's admission MDS dated 06/05/21. The Administrator stated a modification would be submitted to reflect Resident #49 did not use a non-invasive mechanical ventilator while a resident at the facility.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		8/6/21

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F 655	Continued From page 10 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to complete baseline care plans in conjunction with the Interdisciplinary Team (IDT), resident and/or responsible party and failed to provide the resident or their responsible party with a written summary of the baseline care plan for 6 of 11 sampled residents reviewed (Resident #49, #3, #4, #226, #232, and #240). Findings included: 1. Resident #49 was admitted on 06/01/21 with multiple diagnoses that included nontraumatic	F 655	1.Corrective action for resident(s) affected by the alleged deficient practice. All 6 residents identified of the alleged deficient practice have since been discharged from the facility. 2.Corrective action for the residents with the potential to be affected by the alleged practice. An audit will be conducted for all current short-term residents to ensure that the baseline careplan has been developed by the IDT, signed off as complete and provided to the resident/responsible party.	

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F 655	Continued From page 11 intracranial hemorrhage (occurs when a blood vessel in the brain ruptures and causes bleeding inside the brain), diabetes, emphysema, aphasia (loss of ability to understand or express speech, caused by brain damage), repeated falls, and dysphagia (trouble swallowing). The admission Minimum Data Set (MDS) dated 06/05/21 coded Resident #49 with severe cognitive impairment for daily decision making. The MDS noted he required extensive to total staff assistance with all activities of daily living and received oxygen therapy during the MDS assessment period. The computerized baseline care plan initiated on 06/01/21 noted Resident #49 was admitted for short-term rehab to improve function and contained preprinted sections with boxes to check that indicated the sections were reviewed and/or completed by members of the IDT. Further review revealed the following sections had no boxes checked or comments noted: discharge planning, social services, or signature of resident and/or Responsible Party (RP). Additionally, there was no documentation included on the form in the areas for staff in attendance to list their names, department, or their signature. The baseline care plan had no completion date or evidence a copy was provided to the resident and/or RP. During a telephone interview on 07/07/21 at 12:20 PM, Resident #49's RP stated she met with the IDT to discuss his plan of care and discharge goals but was not provided a written summary of the baseline care plan. During an interview on 07/09/21 at 4:08 PM, the	F 655	3.Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: The IDT team will be educated/in-serviced by the NHA on the Regulatory Requirement for Baseline Care Plan completion. (completed 7/28/21) The SDC had added the "sign-off" buttons to the baseline care-plan in Matrix Care so that the IDT has the ability to sign off on the baseline care plan electronically. Completed 07/26/2021. Beginning 07/26/2021, each IDT member will report to stand up meeting with their laptops to review each resident admitted from the prior day and/or weekend to discuss and develop the baseline care-plan and set initial goals based on the resident's orders and needs. The Weekend Supervisors will also participate in initiating the baseline careplan. Completed 07/28/21. The Director of Nursing and/or RN designee will ensure the baseline care plan has been developed within 48 hours of admission and provide the family with a summary of the baseline care plan that meets the regulatory requirements though the following audits: The Director of Nursing and/or RN will conduct daily audits for 5 consecutive days to ensure compliance, then audits 3 x week for 3 weeks, then monthly for 3 months. The DON or her designee will ensure the baseline care plan is provided to the resident or their representative once it is	

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 _____	C 07/09/2021

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COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

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F 655	Continued From page 12 Clinical Manager (CM) explained a Registered Nurse (RN) must initiate the baseline care plan but once initiated, any member of the IDT could fill in the information. The CM stated the information included in a baseline care plan was based on the admission assessment and level of care exhibited by the resident during the first 48 hours of their stay. She added it was her understanding that the information included in the baseline care plan provided a "snapshot" of the resident's care needs until they were thoroughly assessed and a comprehensive care plan developed. The CM was not sure when the initial care plan meeting was held with the resident and/or RP or when they were given a written summary of the care plan and stated she personally never provided the resident or their RP a copy of the baseline care plan. The CM stated there was no staff member assigned to ensure baseline care plans were completed within 48 hours of admission. During a joint interview, Social Worker (SW) #1 and SW #2 explained the IDT met with the resident and/or their RP within 7 to 10 after the resident's admission to review the plan of care at which time they also received a copy of the completed baseline care plan; however, they stated if the baseline care plan was not marked complete, then the resident and/or their RP were not provided a copy. During an interview on 07/09/21 at 5:38 PM, the Administrator stated she would expect for the baseline care plans to include input from IDT, be completed within 48 hours of the resident's admission and a written summary of the care plan provided to the resident and/or their responsible party.	F 655	signed off as complete. 4.Monitoring Procedure to ensure the plan of correction is effective and that that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. The results of the audits will be reviewed at the QAPI meetings to identify compliance / trends and if changes are needed to make those adjustments. * Completion date 08/06/2021.	

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	345350	A. BUILDING _____ B. WING _____	C 07/09/2021

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COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

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F 655	Continued From page 13	F 655		

2. Resident #232 was admitted to the facility 06/14/21 with diagnoses including non-Alzheimer's dementia and respiratory failure.

The 5-day Minimum Data Set (MDS) dated 06/18/21 revealed Resident #232 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, and toilet use.

Review of the computerized baseline care plan initiated 06/14/21 revealed the areas of occupational history, bed mobility, transfer, walking, toileting, high risk black box medication, locomotion, bathing, isolation precautions, eating, grooming/hygiene, equipment, relocation stress, treatments/therapies, and Preadmission Screening and Resident Review (PASRR) recommendation, signatures of the interdisciplinary team (IDT), and signature of the resident or responsible party were blank.

An interview with Clinical Manager on 07/08/21 at 04:15 PM revealed a Registered Nurse (RN) must initiate the baseline care plan and complete the baseline care plan. She explained once the baseline care plan was initiated any member of the IDT could document on the baseline care plan. The Clinical Manager stated there was no staff member assigned to ensure completion of baseline care plans within 48 hours of admission.

A joint interview with Social Worker (SW) #1 and SW#2 on 07/09/21 at 02:57 PM revealed an IDT meeting was conducted with the resident and/or responsible party usually 7 to 10 days after admission to review the plan of care. They explained a copy of the baseline care plan was provided to the resident or the responsible party

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	345350	A. BUILDING _____ B. WING _____	C 07/09/2021

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

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F 655	Continued From page 14	F 655		

during the care plan meeting if the baseline care plan was marked as complete.

An interview with the Administrator on 07/09/21 at 05:42PM revealed she expected the baseline care plan to be completed within 48 hours of admission and the IDT should be documenting on the baseline care plan. The Administrator stated the process for completing the baseline care plan within 48 hours needed to be revamped.

3. Resident #240 was admitted to the facility 06/29/21 with diagnoses including heart failure, diabetes, and back pain.

The admission MDS for Resident #240 was opened but had not been completed at the time of the survey.

The baseline care plan for Resident #240 initiated 06/30/21 was completely blank.

An interview with Clinical Manager on 07/08/21 at 04:15 PM revealed a Registered Nurse (RN) must initiate the baseline care plan and complete the baseline care plan. She explained once the baseline care plan was initiated any member of the IDT could document on the baseline care plan. The Clinical Manager stated there was no staff member assigned to ensure completion of baseline care plans within 48 hours of admission.

A joint interview with Social Worker (SW) #1 and SW#2 on 07/09/21 at 02:57 PM revealed an IDT meeting was conducted with the resident and/or responsible party usually 7 to 10 days after admission to review the plan of care. They explained a copy of the baseline care plan was provided to the resident or the responsible party

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	345350	A. BUILDING _____ B. WING _____	C 07/09/2021

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
F 655	Continued From page 15	F 655		

during the care plan meeting if the baseline care plan was marked as complete.

An interview with the Administrator on 07/09/21 at 05:42PM revealed she expected the baseline care plan to be completed within 48 hours of admission and the IDT should be documenting on the baseline care plan. The Administrator stated the process for completing the baseline care plan within 48 hours needed to be revamped.

4. Resident #3 was admitted to the facility 06/30/21 with diagnoses including cancer, heart failure, and a wound infection.

The 5-day MDS dated 07/04/21 for Resident #3 was opened but had not been completed at the time of the survey.

Review of Resident #3's baseline care plan initiated 06/30/21 revealed occupational history, PASRR recommendation, signatures of IDT members, and signature of the resident or responsible party were blank.

An interview with Clinical Manager on 07/08/21 at 04:15 PM revealed a Registered Nurse (RN) must initiate the baseline care plan and complete the baseline care plan. She explained once the baseline care plan was initiated any member of the IDT could document on the baseline care plan. The Clinical Manager stated there was no staff member assigned to ensure completion of baseline care plans within 48 hours of admission.

A joint interview with Social Worker (SW) #1 and SW#2 on 07/09/21 at 02:57 PM revealed an IDT meeting was conducted with the resident and/or responsible party usually 7 to 10 days after

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 _____	C 07/09/2021

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
F 655	Continued From page 16	F 655		

admission to review the plan of care. They explained a copy of the baseline care plan was provided to the resident or the responsible party during the care plan meeting if the baseline care plan was marked as complete.

An interview with the Administrator on 07/09/21 at 05:42PM revealed she expected the baseline care plan to be completed within 48 hours of admission and the IDT should be documenting on the baseline care plan. The Administrator stated the process for completing the baseline care plan within 48 hours needed to be revamped.

5. Resident #4 was admitted to the facility 06/30/21 with a diagnosis of diabetes.

The admission MDS dated 07/04/21 for Resident #4 was opened but had not been completed at the time of the survey.

Review of Resident #4's baseline care plan initiated 06/30/21 revealed occupational history, grooming/hygiene, social services, PASRR recommendation, signatures of IDT members, and signature of the resident or responsible party were blank.

An interview with Clinical Manager on 07/08/21 at 04:15 PM revealed a Registered Nurse (RN) must initiate the baseline care plan and complete the baseline care plan. She explained once the baseline care plan was initiated any member of the IDT could document on the baseline care plan. The Clinical Manager stated there was no staff member assigned to ensure completion of baseline care plans within 48 hours of admission.

A joint interview with Social Worker (SW) #1 and

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 _____	C 07/09/2021

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

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F 655	Continued From page 17	F 655		

SW#2 on 07/09/21 at 02:57 PM revealed an IDT meeting was conducted with the resident and/or responsible party usually 7 to 10 days after admission to review the plan of care. They explained a copy of the baseline care plan was provided to the resident or the responsible party during the care plan meeting if the baseline care plan was marked as complete.

An interview with the Administrator on 07/09/21 at 05:42PM revealed she expected the baseline care plan to be completed within 48 hours of admission and the IDT should be documenting on the baseline care plan. The Administrator stated the process for completing the baseline care plan within 48 hours needed to be revamped.

6. Resident #226 was admitted to the facility 06/25/21 with a diagnosis of peripheral vascular disease (a circulatory condition which reduces blood flow to the limbs).

The admission MDS dated 07/01/21 for Resident #226 was opened but not completed at the time of the survey.

Review of Resident #226's baseline care plan initiated 06/26/21 revealed occupational history, anticoagulation therapy, high risk black box medications, treatments/therapies, discharge planning, social services, PASRR recommendation, signatures of IDT members, and signature of the resident or responsible party were blank.

An interview with Clinical Manager on 07/08/21 at 04:15 PM revealed a Registered Nurse (RN) must initiate the baseline care plan and complete the baseline care plan. She explained once the

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	345350	A. BUILDING _____ B. WING _____	C 07/09/2021

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

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F 655	Continued From page 18 baseline care plan was initiated any member of the IDT could document on the baseline care plan. The Clinical Manager stated there was no staff member assigned to ensure completion of baseline care plans within 48 hours of admission. A joint interview with Social Worker (SW) #1 and SW#2 on 07/09/21 at 02:57 PM revealed an IDT meeting was conducted with the resident and/or responsible party usually 7 to 10 days after admission to review the plan of care. They explained a copy of the baseline care plan was provided to the resident or the responsible party during the care plan meeting if the baseline care plan was marked as complete. An interview with the Administrator on 07/09/21 at 05:42PM revealed she expected the baseline care plan to be completed within 48 hours of admission and the IDT should be documenting on the baseline care plan. The Administrator stated the process for completing the baseline care plan within 48 hours needed to be revamped.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		8/6/21

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 _____	C 07/09/2021

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

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F 656	Continued From page 19 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive, individualized care plan that addressed the areas: indwelling catheter and anticoagulant, diuretic and opioid medication use for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #35). Findings included:	F 656	1.Corrective action for resident(s) affected by the alleged deficient practice. The resident□s (Resident #35)care plan with the alleged deficient practice has been updated to include the areas noted in the SOD. 2.Corrective action for the residents with the potential to be affected by the alleged	

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	345350	A. BUILDING _____ B. WING _____	C 07/09/2021

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

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F 656	Continued From page 20 Resident #35 admitted to the facility on 03/09/21 with multiple diagnoses that included heart disease, diabetes, hypertension, localized edema (swelling due to excess fluid accumulation in the body tissues), pain, and dysuria (painful or difficult urination). The quarterly Minimum Data Set (MDS) dated 05/25/21 coded Resident #35 with moderate impairment in cognition and the presence of an indwelling catheter. The MDS noted she received the following medications daily during the MDS assessment period: anticoagulant (blood thinner), diuretic (medication used to help the body get rid of extra fluid and salt), and opioid (pain medication). Review of Resident #35's Medication/Treatment Administration Records for the months of June 2021 and July 2021 revealed the following physician orders: 04/13/21: Tramadol (pain medication) 50 milligrams (mg) every 6 hours as needed. Discontinued on 06/14/21. 04/30/21: Change indwelling catheter monthly on the 29th. 04/30/21: Perform catheter care every shift and as needed. 05/07/21: Gabapentin (pain medication) 100 mg twice a day. 06/17/21: Eliquis (anticoagulant) 2.5 milligrams (mg) twice a day with instructions to stop Eliquis on 06/21/21 in anticipation of surgery. 06/21/21: Eliquis 2.5 mg twice a day. 06/27/21: Hydrocodone-acetaminophen (pain medication) 5-325 mg every 6 hours as needed. 07/07/21: Torsemide (diuretic) 20 mg once a day.	F 656	practice. Director of Nursing along with the IDT team will audit the comprehensive careplans to validate that the careplans are person-centered and consistent with resident current status. 3.Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: The Director of Nursing and/or NHA will educate the IDT regarding the need to validate that the careplan is actually comprehensive and that all current information regarding the care of the resident is accurately reflected on the careplan with services, goals, timeframes, resident preferences and the discharge plan. Completed on 07/30/2021 4.Monitoring Procedure to ensure the plan of correction is effective and that that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. The Director of Nursing and/or designee will complete an audit reviewing at least 2 comprehensive careplans weekly for the next 4 weeks and then monthly for 3 months. The results of the audit will be reviewed at the QAPI meeting for compliance and trends and the plan will be adjusted as/if needed. *Completion date will be no later than 08/06/2021.	

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 _____	C 07/09/2021

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

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F 656	Continued From page 21	F 656		

Review of Resident #35's active care plans, last reviewed/revised 05/26/21, revealed no care plans that addressed catheter care, anticoagulant, diuretic or pain medication use.

During an interview on 07/09/21 at 1:11 PM, MDS Coordinator #2 explained she was new to the MDS position and was not trained to develop specific care plans, such as an indwelling catheter or anticoagulant medication use; however, the problem areas would be addressed under the category they triggered on the MDS assessment. MDS Coordinator #2 confirmed there were no care plans that addressed Resident 35's indwelling catheter or her use of anticoagulant, diuretic and pain medications and stated those areas should have been addressed.

During a telephone interview on 07/09/21 at 2:37 PM, MDS Coordinator #1 explained both she and MDS Coordinator #2 were new to the MDS position and confirmed comprehensive care plans were developed based off the triggers from the Care Area Assessment (CAA) of the MDS. She added they still had a lot to learn and the only explanation she could provide was it was an error on their part that Resident #35's indwelling catheter and use of anticoagulant, diuretic and pain medications were not addressed in her comprehensive care plan.

During an interview on 07/09/21 at 5:38 PM, the Administrator explained the MDS Coordinators were new to the positions and likely did not know that specific care plans could be developed when the problem area did not trigger on the MDS. She added more training would be provided to the MDS Coordinators related to developing comprehensive care plans.

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 _____	C 07/09/2021

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

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise and update a care plan related to an upgraded diet for 1 of 18 sampled residents (Resident #49). Findings included: Resident #49 was admitted to the facility on	F 657	1.Corrective action for resident(s) affected by the alleged deficient practice. The resident identified (#49) with the alleged deficient practice has been discharged. 2.Corrective action for the residents with the potential to be affected by the alleged	7/30/21

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 _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 23 06/01/21 with diagnoses that included dysphagia (difficulty swallowing food or liquid). The baseline care plan initiated on 06/01/21 noted under the eating section that Resident #49 had a feeding tube (medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation) and under the diet section was noted NPO (no solids or fluids by mouth), feeding tube and at risk for weight loss. The admission Minimum Data Set (MDS) dated 06/05/21 coded Resident #49 with severe cognitive impairment. The MDS noted he required extensive staff assistance with eating and received 51 percent or more of total calories through a feeding tube. Review of Resident #49's active care plans, initiated on 06/10/21, revealed a nutrition care plan in place that read in part he was at risk for weight loss due to dysphagia and NPO status. The care plan noted his nutritional needs were provided through a feeding tube. Review of Resident #49's medical record revealed a physician's order dated 06/27/21 read, "Diet: puree and nectar thick liquids." During an interview on 07/09/21 at 1:11 PM, MDS Coordinator #2 reviewed the physician's order dated 06/27/21 and could not explain why Resident #49's nutrition care plan was not updated to reflect the change in his diet. MDS Coordinator #2 stated she thought it would be the responsibility of dietary to revise the care plan with changes in diet or inform her and MDS	F 657	practice. Chart audit will be completed for all current residents with a feeding tube to ensure any upgrades to the diet order has been properly added to the careplan timely to ensure accuracy of the careplan. (Completed 07/12/21) 3.Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: The process for care plan timing and revision has been reviewed with the IDT. Education was provided to the registered dieticians and the IDT team by the NHA on 07/29/2021 regarding care plan updates and revisions related to timeliness and that the care plan must be reviewed and revised by the IDT team after each assessment, including both the comprehensive, quarterly and with a significant change. All existing residents with feeding tubes have been audited and the one resident with a feeding tube is accurately care planned. The DON/designee will conduct audits on all residents with a feeding tube for any needed diet revisions and updates as follows: *Care plans of resident with feeding tubes will be audited for diet upgrades/downgrades by the DON and/or designee weekly x 4 weeks to ensure compliance and then monthly x 3 months.	

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 _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 24 Coordinator #1 so they could update the care plan. During a telephone interview on 07/09/21 at 2:37 PM, MDS Coordinator #1 explained both she and MDS Coordinator #2 were new to the MDS position and was not sure who was ultimately responsible for revising/updating care plans. She added they still had a lot to learn and the only explanation she could provide was it was an error and part of the learning process. During an interview on 07/09/21 at 5:38 PM, the Administrator explained the MDS Coordinators currently did not attend the weekly meetings where residents at risk were discussed and felt it would be good to start including them in the meetings so they would be aware of changes and new orders for the resident care plans to be updated/revised accordingly.	F 657	4.Monitoring Procedure to ensure the plan of correction is effective and that that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. Results of the above audit will be presented and reviewed at the QAPI meeting for compliance and trends and changes made when/if needed. *This item was completed on 07/30/21	