STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD 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 onsite recertification and complaint survey was conducted on 1/31/22 through 2/3/22. Additional information was obtained through 2/17/22. Therefore, the exit date was changed to 2/17/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6KJN11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted 1/31/22 through 2/3/22. Additional information was obtained through 2/17/22. Therefore, the exit date was changed to 2/17/22. (Event ID #6KJN11). A total of 5 allegations were investigated and 1 allegation was substantiated. Immediate Jeopardy was identified at: 483.25 at tag F 686 at a scope and severity of J 483.10 at tag F 580 at a scope and severity of J Immediate Jeopardy began on 12/19/21 and was removed on 2/13/22. An extended survey was completed.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		3/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/11/2022

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 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580

Continued From page 2

under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record reviews, responsible party, staff, and Nurse Practitioner interviews, the facility failed to notify the physician of the deterioration of a stage 2 decubitus ulcer (also known as a bed sore that is an injury to the skin and underlying tissues resulting from prolonged pressure on the area) to a stage 4 decubitus ulcer with tunneling and sepsis. The facility also failed to notify the Responsible Party (RP) of the development and deterioration of a pressure ulcer. This was for 1 of 3 residents (Resident #106) reviewed for notification of changes.

Immediate jeopardy began on 12/19/21 when Resident #106 was observed by staff with a deteriorated pressure ulcer with tunneling of the wound and staff failed to notify the physician. The resident was hospitalized on 12/22/21 when she was unresponsive and was diagnosed with a stage 4 decubitus ulcer with tunneling and sepsis and died in the hospital on 12/23/21. The immediate jeopardy was removed on 02/13/22 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example 1b was cited a scope and severity level of "D".

The findings included:

1. Resident #106 was admitted to the facility on 09/21/13.

F 580

THE ROOT CAUSE ANALYSIS AND DIRECTED PLAN OF CORRECTION WILL FOLLOW AS AN ATTACHMENT TO THIS PLAN OF CORRECTION. THE ROOT CAUSE ANAYLSIS WAS COMPLETED IN CONJUNCTION WITH THE QUALITY ASSURANCE COMMITTEE.

ALEXANDRIA PLACE□S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY LAW.

" F-580:

CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

Resident #106 is no longer a resident at Alexandria Place and therefore, no interventions are needed for Resident # 106.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 3 Resident #106's quarterly Minimum Data Set dated 10/07/21 revealed she was moderately cognitively impaired. 1a. An interview on 02/03/22 at 5:30 PM with Nurse #1 assigned to Resident #106 on 12/09/21 revealed she observed Resident #106's bottom and described she had several different areas on her bottom and coccyx with one area that resembled a blister with fluid in it. Nurse #1 said she had done the dressing on Resident #106 on 12/09/21, 12/12/21, 12/15/21 and 12/18/21 and said the wound had progressively gotten redder and was larger than when it was first noted on 12/09/21. Nurse #1 indicated she had not contacted the physician or Nurse Practitioner (NP) to notify them of the wound's progression after 12/09/21. A Nurse Practitioner (NP) progress note dated 12/10/21 revealed the resident was being seen for "follow up visit for evaluation of buttocks breakdown." Integumentary (includes the skin and all its layers) was noted as being positive for poor healing of wounds. The wounds were described in the notes as "multiple denuded areas with top layer of skin sheared off over bilateral upper/posterior thighs, buttocks, and coccyx." An interview on 02/02/22 at 11:49 AM with Nurse Aide (NA) #2 revealed she had taken care of Resident #106 on 12/19/21 and had asked the Director of Nursing (DON) to come into her room to look at the residents wound. NA #2 stated the wound was red with some bleeding in some areas and there were areas of black on the wound. The NA stated she could not remember	F 580	HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Alexandria Place has identified that all residents have the potential to be affected by this practice. The facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all notifications to the Attending Physician, contract wound doctor, and Responsible Party concerning wounds. This Administrative Licensed Practical Nurse has been in-serviced on 02/11/2022 by an outside facility consultant concerning notifying the attending physician, contract wound doctor, and Responsible Party about any changes to wounds. The Director of Nursing and two Nurse Managers were also in-serviced by the outside facility consultant on the same topic on 02/11/2022. If the Administrative Licensed Practical Nurse is not working at the time that a worsening of the wound is noted, the Floor nurse will be responsible for notifying the Attending Physician and Responsible Party.	

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F 580

Continued From page 4

the wound having a foul odor but said it could have and she just didn't remember. NA #2 stated the wound looked worse than the last time she had seen it and taken care of the resident on 12/15/21.

An interview on 02/03/22 at 6:42 PM with the Director of Nursing (DON) revealed she had been at the facility on 12/19/21. The DON stated she had been asked by the NA (could not recall her name) taking care of the resident on 12/19/21 to come into the room and look at her wounds while she was performing incontinence care. The DON stated she went into the room and looked at the wounds on her buttocks and coccyx and stated the pressure ulcer had worsened and appeared as though the wound was tunneling. The DON indicated she placed a note in the provider book for the NP to see the resident on her next rounds. The DON explained the NP was at the facility 3 days per week and available by phone as needed but said she had not called her when she noticed the wound had worsened but had opted to place a note in the provider book.

A nursing progress noted dated 12/22/21 written at 6:38 PM by Nurse #5 revealed Resident #106 was "observed not in her baseline orientation this morning. Not able to respond to commands, not able to stick her tongue out. No grasp reflex. Not her usual self. DON notified for comparison to normal baseline. Directed from DON to call family and ask if they wanted resident sent out. Family member requested send to emergency department for further evaluation. On call contacted. NP gave order to send to ED (emergency department) to rule out possible transient ischemic attack (TIA)/stroke. Vital signs 107/65, 105, 99.0, 97% and blood sugar 127."

F 580

An outside facility consultant has in-serviced all Nurses that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Attending Physician and Responsible Party concerning changes in condition and worsening of wounds. These in-services included the Director of Nursing, Nurse Managers, and Administrative Licensed Practical Nurse as participants. The Director of Nursing will continue to in-service all staff 02/11/2022 □ 02/12/2022 to ensure that all staff have received in-servicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be in-serviced at the start of their shift to ensure that they are aware of the facility□s protocol. Nurses that have not been in-serviced by 2/12/2022 will receive the in-service prior to working on the floor.

All CNAs working on 02/11/2022 have been in-serviced by the outside facility consultant on what skin changes they need to watch for and to report these to the unit nurse. These in-services included the Director of Nursing as a participant. The Director of Nursing will continue to in-service all staff 02/11/2022 □ 02/12/2022 to ensure that all staff have received in-servicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be in-serviced at the start of their shift to ensure that they are aware of the facility□s protocol and what to do in the event that a skin issue appears during

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F 580 Continued From page 5

Resident #106's hospital admission notes revealed she was admitted to the local hospital on 12/22/21 through the emergency department (ED) to the ICU (Intensive Care Unit). The resident was evaluated for generalized weakness and altered metal status. The resident had a decubitus ulcer that was undergoing treatment at the facility where she resided. The resident was diagnosed with acute kidney injury, hepatic encephalopathy, hypernatremia, lactic acidosis, respiratory failure, and sacral wound. The resident had a large foul-smelling decubitus ulcer that would likely require surgical evaluation and possibly debridement. They placed a urinary catheter in the ED and gave her bolus fluids, intubated her per the responsible party's (RP) request and admitted her for further management and stabilization to the critical care unit. The resident was initiated on broad-spectrum antibiotics for her sepsis, and it was suspected the wound was the source of her infection. The critical care physician shared with the RP the resident needed surgical intervention for the wound but given her overall condition it was suspected she would not survive surgery, so the family member decided not to actively treat her but to extubate her, provide her with fluids, and make her comfortable. The resident died in the hospital on 12/23/21 at 4:30 PM. Her death according to the hospital records was attributed to severe sepsis.

A phone interview with the Nurse Practitioner (NP) on 02/01/22 at 3:12 PM revealed she saw the resident on 12/10/21 and she had multiple denuded areas of sheared skin on her buttocks and coccyx area. She stated she expected the nurses to have notified her of the worsening of

F 580

their shift. CNAs that have not been in-serviced by 2/12/2022 will receive the in-service prior to working on the floor.

MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:

The facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all notifications to the Attending Physician, contract wound doctor, and Responsible Party concerning wounds. This Administrative Licensed Practical Nurse has been in-serviced on 02/11/2022 by an outside facility consultant concerning notifying the attending physician, contract wound doctor, and Responsible Party about any changes to wounds. The Director of Nursing and two Nurse Managers were also in-serviced by the outside facility consultant on the same topic on 02/11/2022. If the Administrative Licensed Practical Nurse is not working at the time that a worsening of the wound is noted, the Floor nurse will be responsible for notifying the Attending Physician and Responsible Party.

An outside facility consultant has in-serviced all Nurses that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Attending

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 580

Continued From page 6

the wound and she would have re-evaluated her wounds and possibly ordered a urinary catheter to be placed. According to the NP, had she known the wound had gotten worse she would have referred Resident #106 to the wound physician.

An interview on 02/03/22 at 6:42 PM with the DON revealed she couldn't explain why the physician or NP had not been notified of her worsening decubitus ulcer but stated she expected all changes especially any worsening changes to be communicated to the NP or physician.

An interview on 02/03/22 at 7:32 PM with the Administrator revealed she expected skin changes and wound changes to be discussed with the NP or physician.

The nursing home Administrator was notified of Immediate Jeopardy on 02/11/22 at 9:43 AM.

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

The facility has identified that the use of Staffing Agency personnel led to a breakdown in the system for reporting skin issues and notification of the resident's Attending Physician. The use of multiple Staffing Agency personnel resulted in a failure to report skin issues by the agency CNAs and Agency Nurses. These issues led to a delay in Resident #106's wound deterioration being evaluated by the provider.

The Director of Nursing was not aware that the Nurse Practitioner had not been notified of the

F 580

Physician and Responsible Party concerning changes in condition and worsening of wounds. These in-services included the Director of Nursing, Nurse Managers, and Administrative Licensed Practical Nurse as participants. The Director of Nursing will continue to in-service all staff 02/11/2022 02/12/2022 to ensure that all staff have received in-servicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be in-serviced at the start of their shift to ensure that they are aware of the facilitys protocol. Nurses that have not been in-serviced by 2/12/2022 will receive the in-service prior to working on the floor.

All CNAs working on 02/11/2022 have been in-serviced by the outside facility consultant on what skin changes they need to watch for and to report these to the unit nurse. These in-services included the Director of Nursing as a participant. The Director of Nursing will continue to in-service all staff 02/11/2022 02/12/2022 to ensure that all staff have received in-servicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be in-serviced at the start of their shift to ensure that they are aware of the facilitys protocol and what to do in the event that a skin issue appears during their shift. CNAs that have not been in-serviced by 2/12/2022 will receive the in-service prior to working on the floor.

Additionally, the Director of Nursing will

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	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 580 Continued From page 7

worsening of the wound. She placed a note in the provider book for the Nurse Practitioner, but she had not notified the Nurse Practitioner by phone. Nurse #1 also placed a note in the provider book but had not notified the Nurse Practitioner by phone. The missing note from Nurse #1 and the Director of Nursing that were placed in the provider book have not been found.

Resident #106 is no longer a resident at Alexandria Place and therefore, no interventions are needed for Resident # 106.

Alexandria Place has identified that all residents have the potential to be affected by this practice.

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 facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all notifications to the Attending Physician and contract wound doctor concerning wounds. This Administrative Licensed Practical Nurse has been inserviced on 02/11/2022 by an outside facility consultant concerning notifying the attending physician and contract wound doctor about any changes to wounds. The Director of Nursing and two Nurse Managers were also inserviced by the outside facility consultant on the same topic on 02/11/2022. If the Administrative Licensed Practical Nurse is not working at the time that a worsening of the wound is noted, the Floor nurse will be responsible for notifying the Attending Physician.

An outside facility consultant has inserviced all

F 580

review all wound documentation weekly for six (6) weeks, bi-weekly for six (6) weeks, and monthly for six (6) months to ensure that the Attending Physician, contract wound doctor, and Responsible Party have been notified of any worsening of a wound. The Director of Nursing will document her reviews of documentation on a Quality Assurance form and will present this form to the Quality Assurance Committee for review.

HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S EFFECTIVENESS:

The Director of Nursing will review all wound documentation weekly for six (6) weeks, bi-weekly for six (6) weeks, and monthly for six (6) months to insure that the Attending Physician, contract wound doctor, and Responsible Party have been notified of any worsening of a wound. The Director of Nursing will document her reviews of documentation on a Quality Assurance form and will present this form to the Quality Assurance Committee for review.

The Director of Nursing□s Quality Assurance checks will also be reviewed by the QAPI Committee to ensure that the solution is achieved, effective, and sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 8	F 580		

Nurses that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Attending Physician concerning changes in condition and worsening of wounds. These inservices included the Director of Nursing, Nurse Managers, and Administrative Licensed Practical Nurse as participants. The Director of Nursing will continue to inservice all staff 02/11/2022 - 02/12/2022 to ensure that all staff have received inservicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be inserviced at the start of their shift to ensure that they are aware of the facility's protocol. Nurses that have not been inserviced by 2/12/2022 will receive the inservice prior to working on the floor.

All CNAs working on 02/11/2022 have been inserviced by the outside facility consultant on what skin changes they need to watch for and to report these to the unit nurse. These inservices included the Director of Nursing as a participant. The Director of Nursing will continue to inservice all staff 02/11/2022 - 02/12/2022 to ensure that all staff have received inservicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be inserviced at the start of their shift to ensure that they are aware of the facility ' s protocol and what to do in the event that a skin issue appears during their shift. CNAs that have not been inserviced by 2/12/2022 will receive the inservice prior to working on the floor.

Date of alleged Immediate Jeopardy Removal: 02/13/2022. Person responsible for the implementation is the Administrator.

On 02/17/22 the facility's credible allegation was

Date of Compliance is 03/11/2022.

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	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 580	Continued From page 9 validated through record reviews, staff, and resident interviews. The facility provided education through an outside facility consultant to all nurses on the proper protocol for notifications to the attending physician, nurse practitioner and wound physician any changes to skin integrity or current wounds. A nurse had been designated as the wound nurse and she will be completing all notifications to the providers concerning skin changes and changes in wounds. The nurse has been inserviced by an outside facility consultant concerning when notifications should be made to all providers. The Director of Nursing, Nurse Managers and all Administrative nurses were included in the inservice by the facility consultant. The facility provided signed education sheets on the new system for notification of changes to providers and responsible parties. Interviews conducted with the wound nurse, and administrative nurses validated their responsibilities for notifying the providers of any skin or wound changes in residents. The nurses interviewed were able to explain with accuracy their responsibilities for notifying providers of changes. Nursing assistants were interviewed and described the changes in skin integrity they were expected to watch for when providing resident care and who to report the skin changes to during their shift. The Director of Nursing (DON) will continue to inservice new staff, and new agency staff on the proper protocol for reporting skin changes and what to do in the event of a skin change in residents. The facility provided signed education sheets for the nursing assistants working outlining the skin changes and who they were to report the changes to on their shift. The nursing assistants interviewed were able to	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ____ B. WING ____	C 02/17/2022

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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 580	Continued From page 10	F 580		

explain with accuracy what skin changes were to be reported and to whom they were to be reported.

The Director of Nursing was interviewed and was able to describe in detail the new system for reporting changes to ensure changes are identified and reported timely to the providers and responsible parties of the residents. The DON explained she or her designee verified the sheets that identified skin changes and then verified they were reported, and a progress note had been completed.

The Administrator was interviewed and described in detail her education with the Nurse Practitioner (NP), Facility Medical Director and Wound physician regarding notification of changes in skin and wounds and their responsibilities for collaboration regarding wounds and notifications to the residents and responsible parties if wounds worsen and their management plan.

A resident identified by the facility as alert and oriented with a wound was interviewed and reported she and her son were kept informed by the nurse and Wound Physician of the progress of her stage II wound.

The credible allegation for the immediate jeopardy removal was validated on 02/17/22 with a removal date of 02/13/22.

1b. An interview on 02/03/22 at 5:30 PM with Nurse #1 assigned to Resident #106 on 12/09/21 revealed she observed Resident #106's bottom and described she had several different areas on her bottom and coccyx with one area that resembled a blister with fluid in it. Nurse #1 said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 580	Continued From page 11 she had done the dressing on Resident #106 on 12/09/21, 12/12/21, 12/15/21 and 12/18/21 and said the wound had progressively gotten redder and was larger than when it was first noted on 12/09/21. Nurse #1 stated she had not notified Resident #106's responsible party (RP) of the skin changes or the worsening wound on Resident #106's buttocks and coccyx. A Nurse Practitioner (NP) progress note dated 12/10/21 revealed the resident was being seen for "follow up visit for evaluation of buttocks breakdown." Integumentary was noted as being positive for poor healing of wounds. The wounds were described in the notes as "multiple denuded areas with top layer of skin sheared off over bilateral upper/posterior thighs, buttocks, and coccyx." An interview on 02/02/22 at 11:49 AM with Nurse Aide (NA) #2 revealed she had taken care of Resident #106 on 12/19/21 and had asked the Director of Nursing (DON) to come into her room to look at the residents wound. NA #2 stated the wound was red with some bleeding in some areas and there were areas of black on the wound. NA #2 stated the wound looked worse than the last time she had seen it and taken care of the resident on 12/15/21. An interview on 02/03/22 at 6:42 PM with the Director of Nursing (DON) revealed she had been at the facility on 12/19/21. The DON stated she had been asked by the NA (could not recall her name) taking care of the resident on 12/19/21 to come into the room and look at her wounds while she was performing incontinence care. The DON stated she went into the room and looked at the wounds on her buttocks and coccyx and stated	F 580		

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F 580	Continued From page 12 the pressure ulcer had worsened and appeared as though the wound was tunneling. Additionally, the DON stated she had not notified Resident #106's responsible party (RP) of the wound changes and stated she could not remember why she had not notified the RP of the changes but said she should have notified her when the wound had worsened. A phone interview on 02/01/22 with Resident #106's family member revealed she was the responsible party (RP) for the resident. The RP stated she had visited the resident at the facility on 12/15/21 and was not told the resident had any skin breakdown. The RP indicated she was not aware of Resident #106's worsening decubitus ulcer until she was notified by the hospital emergency department physician that the resident had a stage IV decubitus ulcer with tunneling and severe sepsis. The RP further indicated she should have been notified and kept apprised of the resident's wound and treatment and progress of the wound. An interview on 02/03/22 at 6:42 PM with the DON revealed she couldn't explain why Resident #106's skin changes had not been reported to the responsible party (RP) and why the RP had not been notified of the worsening condition of the resident's wound. The DON stated the RP should have been notified of the skin changes and the wound worsening as soon as it had occurred. An interview on 02/03/22 at 7:32 PM with the Administrator revealed she expected responsible parties and any interested family members to be notified of any and all changes in residents.	F 580		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months	F 638		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 638	Continued From page 13 CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 3 of 14 sampled residents reviewed (Residents #20, #23 and #24). The findings included: 1.Resident #20 was admitted to the facility on 12/17/20. A review of Resident #20's electronic chart revealed the most recent completed MDS assessment was a quarterly dated 10/14/21. An interview conducted with the MDS Coordinator on 2/3/22 at 3:51 PM revealed Resident #20 had no further MDS assessments since October. The MDS coordinator further revealed she had been pulled from her MDS duties to assist staff and complete tasks for the facility and had not been able to complete multiple MDS assessments that were due in January. The MDS coordinator stated it was expected for her to have resident MDS assessments completed every 90 days. An interview conducted with the Director of Nursing (DON) on 2/3/22 at 6:32 PM revealed	F 638	" F-638: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Quarterly Minimum Data Set assessments for residents #20, #23, and #24 have been completed by the facility Minimum Data Set Coordinator. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident has the potential to be affected by this practice. All residents have been reviewed to ensure that current Quarterly Minimum Data Set Assessments have been completed in accordance with the time frames as specified in the Resident Assessment Instrument manual. Any assessments that were found to not be completed in the required time frame have been completed.	

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F 638

Continued From page 14

she was not aware that Resident #20 had a missed quarterly MDS. The DON further revealed it was expected for Residents to have an MDS assessment every 90 days.

An interview conducted with the Administrator on 2/3/22 at 7:26 PM revealed she was not aware that Resident #20's MDS had not been completed. The Administrator further revealed the MDS Coordinator had been pulled to assist with the facility outbreak but expected for residents MDS assessments to be completed in a timely manner.

2. Resident #23 was admitted to the facility on 7/15/2021.

Review of Resident #23's electronic medical record revealed the most recent quarterly MDS assessment was completed on 10/17/2021. Further review of the electronic medical record revealed there were no subsequent MDS assessments completed or in progress.

Interview with the MDS Coordinator on 2/2/2022 at 3:34 PM revealed she had not completed an MDS for Resident #23 since October. The MDS Coordinator disclosed she had been on leave for several weeks. The MDS Coordinator indicated following her return to work, she had been working in direct resident care as well as performing other facility duties for the past several months. The MDS Coordinator stated she knew she was responsible for completing resident MDS every 90 days.

Interview with the Director of Nursing (DON) on 2/3/2022 at 6:26 PM revealed she was aware

F 638

MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:

The facility Minimum Data Set Coordinator was in-serviced on 3/09/2022 by an facility Consultant Minimum Data Set Nurse on the importance of completing quarterly Minimum Data Sets. The facility Minimum Data Set Coordinator will use a calendar to note when a resident□s Minimum Data Set assessment is due and will present that calendar to the facility Administrator at the start of each month. The facility Administrator will then review all Minimum Data Set Assessments to ensure that they are completed timely in accordance with the Resident Assessment Instrument manual. The Administrator will record the results of her review on a Quality Assurance Form.

HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S EFFECTIVENESS:

The facility Administrator will then review all Minimum Data Set Assessments to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 638	Continued From page 15 MDS were not being done. The DON stated while resident care came first, she understood the requirements for completing the MDS. The DON indicated her expectation was that MDS were completed according to the timeframes outlined in the Resident Assessment Instrument. 3. Resident #24 was admitted to the facility on 5/2/17. Review of Resident #24's electronic medical record revealed the most recent MDS assessment was coded as a quarterly MDS with an ARD of 10/23/21. There were no other MDS assessments in progress. An interview with the MDS Coordinator on 2/3/22 at 3:53 PM revealed she was aware of MDS assessments that she hadn't completed yet. She stated she hadn't had time to start Resident #24's quarterly MDS but it was in her calendar. The MDS Coordinator stated she had been busy helping move the residents in and out of quarantine since the facility had been in outbreak. She stated she was more concerned about the residents than paperwork. An interview with the Director of Nursing (DON) on 2/3/22 at 6:22 PM revealed she expected to have MDS assessments completed timely. The DON stated the past month had been crazy with residents testing positive and moving residents to the COVID-19 unit. The DON stated it was not surprising that the MDS assessments didn't get completed on time, but it was not acceptable.	F 638	ensure that they are completed timely in accordance with the Resident Assessment Instrument manual. The Administrator will record the results of her review on a Quality Assurance Form and will present the results to the Quality Assurance Committee for review. The results will also be presented to the QAPI Committee for review to ensure that the solution is achieved, sustained, and effective. Date of Compliance is 03/11/2022.	

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F 640	Continued From page 16	F 640		
F 640 SS=E	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.	F 640		3/11/22

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F 640	Continued From page 17 (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 review and staff interviews, the facility failed to complete and transmit Minimum Data Set (MDS) assessments within the regulatory timeframes as specified in the Resident Assessment Instrument (RAI) manual for 5 of 19 sampled residents reviewed (Residents #9, #1, #7, #10 and #11). The findings included: 1. Resident #9 was admitted to the facility on 5/9/20. Review of Resident #9's electronic medical record revealed the most recent MDS assessment was coded as a quarterly with an Assessment Reference Date (ARD) of 1/7/22. The MDS assessment had a status of "open." An interview with the MDS Coordinator on 2/3/22 at 3:53 PM revealed she was aware of MDS assessments that she hadn't completed and transmitted yet. She knew she had 14 days to complete Resident #9's quarterly MDS assessment and that it had been over 14 days	F 640	" F-640: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Minimum Data Set assessments for residents #9, #1, #7, #10, and #11 have been completed and transmitted. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident has the potential to be affected by this practice. All residents have been reviewed by the facility Administrator to ensure that Minimum Data Set Assessments have been completed and transmitted in accordance with the time frames as specified in the	

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	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 640 Continued From page 18

since the ARD date. The MDS Coordinator stated she hadn't had time because she had been busy helping move the residents in and out of quarantine since the facility had been in outbreak.

An interview with the Director of Nursing (DON) on 2/3/22 at 6:22 PM revealed she expected to have MDS assessments completed timely. The DON stated the past month had been crazy with residents testing positive and moving residents to the COVID-19 unit. The DON stated it was not surprising that the MDS assessments didn't get completed and transmitted on time, but it was not acceptable.

2. Resident #1 was admitted to the facility on 1/5/19.

Review of Resident #1's electronic medical record revealed the most recent MDS assessment was coded as a quarterly with an ARD of 1/1/22. The MDS assessment had a status of "open."

An interview with the MDS Coordinator on 2/3/22 at 3:53 PM revealed she was aware of MDS assessments that she hadn't completed and transmitted yet. She knew she had 14 days to complete Resident #1's quarterly MDS assessment and that it had been over 14 days since the ARD date. The MDS Coordinator stated she hadn't had time because she had been busy helping move the residents in and out of quarantine since the facility had been in outbreak.

An interview with the Director of Nursing (DON) on 2/3/22 at 6:22 PM revealed she expected to

F 640

Resident Assessment Instrument manual. Any assessments that were found to not be completed and transmitted in the required time frame have been completed and transmitted.

MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:

The facility Minimum Data Set Coordinator was in-serviced by the facility Consultant Minimum Data Set Nurse concerning the importance of completing and transmitting the Minimum Data Set as within the specified time frames according to the Resident Assessment Instrument. The facility Minimum Data Set Coordinator will use a calendar to note when a resident□s Minimum Data Set assessment is due and will present that calendar to the facility Administrator at the start of each month. The facility Administrator will then review all Minimum Data Set Assessments to ensure that they are completed and transmitted timely in accordance with the Resident Assessment Instrument manual. The Administrator will record the results of her review on a Quality Assurance Form.

HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 640

Continued From page 19

have MDS assessments completed timely. The DON stated the past month had been crazy with residents testing positive and moving residents to the COVID-19 unit. The DON stated it was not surprising that the MDS assessments didn't get completed and transmitted on time, but it was not acceptable.

3. Resident #7 was admitted to the facility on 01/29/20.

Resident #7 ' s electronic medical record revealed the most recent MDS assessment was coded as an annual with an ARD of 01/05/22. The MDS assessment had a status of "open."

An interview with the MDS Coordinator on 02/03/22 at 3:53 PM revealed she was aware of MDS assessments that she had not completed and transmitted. She knew she had 14 days to complete Resident #7 ' s annual MDS assessment and that it had been over 14 days since the ARD date. The MDS Coordinator stated she had not had time because she had been assisting in moving COVID-19 positive residents in and out of the COVID unit since the facility had been in outbreak.

An interview with the Director of Nursing (DON) on 02/03/22 at 6:22 PM revealed she expected to have MDS assessments completed timely. The DON stated the past month had been crazy with residents testing positive for COVID-19 and moving residents to the COVID unit. The DON stated it was not surprising MDS assessments didn ' t get completed and transmitted on time, but said it was not acceptable.

4. Resident #10 was admitted to the facility on

F 640

EFFECTIVENESS:

The facility Administrator will then review all Minimum Data Set Assessments to ensure that they are completed and transmitted timely in accordance with the Resident Assessment Instrument manual. The Administrator will record the results of her review on a Quality Assurance Form and will present the results to the Quality Assurance Committee for review. The results will also be presented to the QAPI Committee for review to ensure that the solution is achieved, sustained, and effective.

Date of compliance is 03/11/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD 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 640	Continued From page 20	F 640		

10/05/20 and readmitted on 07/23/21.

Resident #10'' s electronic medical record (EMR) revealed the most recent MDS assessment was coded as a quarterly with an ARD date of 01/07/22. The MDS assessment had a status of "open."

An interview with the MDS Coordinator on 02/03/22 at 3:53 PM revealed she was aware of MDS assessments that she had not completed and transmitted. She knew she had 14 days to complete Resident #7 ' s annual MDS assessment and that it had been over 14 days since the ARD date. The MDS Coordinator stated she had not had time because she had been assisting in moving COVID-19 positive residents in and out of the COVID unit since the facility had been in outbreak.

An interview with the Director of Nursing (DON) on 02/03/22 at 6:22 PM revealed she expected to have MDS assessments completed timely. The DON stated the past month had been crazy with residents testing positive for COVID-19 and moving residents to the COVID unit. The DON stated it was not surprising MDS assessments didn ' t get completed and transmitted on time, but said it was not acceptable.

5. Resident #11 was admitted to the facility on 12/17/2019.

Review of Resident #11's MDS revealed a quarterly assessment dated 1/7/2022 had been initiated but not completed or transmitted.

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F 640	Continued From page 21 Interview with the MDS Coordinator on 2/3/2022 at 3:56 PM revealed she had been working in direct resident care and had not had time to complete MDS. The MDS Coordinator stated she had a worksheet of MDS that she had not had time to enter into the system. The MDS Coordinator verbalized her responsibility was to complete the MDS assessments and transmit them every 3 months. Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected MDS to be completed and transmitted according to the required schedules.	F 640		
F 656 SS=E	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 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).	F 656		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD 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 656 — Continued From page 22 — F 656

(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 and implement a comprehensive care plan and interventions for 4 of 4 residents in the areas of wound care (Resident #31); application of anti-embolism stockings (Resident #31, #11); use of oxygen (Resident #23); and smoking (Resident #30).

The findings included:

1.a. Resident #31 was admitted to the facility on 4/9/2018 with diagnoses of coronary artery disease and hypertension.

Review of Resident #31's Physician orders revealed the following:
5/14/2020 - apply antiembolism stockings to

Provider's Plan of Correction:

" F-656:
CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

The noted interventions for residents #31, #11, #23, and #30 have been added to their respective comprehensive care plans and the new care plans have been implemented.

HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 656 Continued From page 23
bilateral lower extremities every morning and remove at bedtime.

Review of Resident #31's care plan dated 5/6/2021 and last updated 11/8/2021 revealed no care plan or interventions related to application of antiembolism stockings.

An interview with the MDS Coordinator on 2/3/2022 at 3:56 PM revealed she was aware care plans had not been updated. The MDS Coordinator indicated she had been pulled to work in direct resident care. She stated resident care came first, but she acknowledged it was her responsibility to complete care plan reviews and updates every 90 days.

An interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected conditions related to active treatments to be included in the care plan.

1.b. Resident #31 was admitted to the facility on 4/9/2018 with diagnoses of coronary artery disease and hypertension.

Review of Resident #31's Physician orders revealed the following:
1/17/2022 - apply antibacterial cream to nasal lesions twice daily.

Review of Resident #31's care plan dated 5/6/2021 and last updated 11/8/2021 revealed no care plan or interventions related to the treatment of lesions on the resident's nose.

Interview with the MDS Coordinator on 2/3/2022 at 3:56 PM revealed she was aware care plans had not been updated. The MDS Coordinator

F 656

CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:

Any resident has the potential to be affected by this practice. All resident care plans have been reviewed by the facility Administrator to ensure that comprehensive care plans have been developed and implemented. Any care plans that were found to not be comprehensive have been updated and implemented.

MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:

The facility Consultant Minimum Data Set Nurse in-serviced the facility Minimum Data Set Coordinator on 03/09/2022 about the requirement of developing, completing, and implementing comprehensive care plans for residents. The facility Minimum Data Set Coordinator will submit completed care plans to the facility Administrator for review so that they can be assessed to ensure that they are comprehensive before being implemented on the unit. The Administrator will review care plans for six (6) months to ensure that the deficient practice does not recur. The facility Administrator will document the results of her review on a Quality Assurance Form and will present the results to the facility Quality Assurance Committee for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 656	Continued From page 24 indicated she had been pulled to work in direct resident care. She stated resident care came first, but she acknowledged it was her responsibility to complete care plan reviews and updates every 90 days. Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected conditions related to active treatments to be included in the care plan. 2. Resident #11 was admitted to the facility on 12/17/2019 with diagnoses of coronary artery disease and chronic congestive heart failure. Review of Resident #11's Physician orders revealed the following: 4/16/2020 - apply antiembolism stockings in the morning and take off in the evening. Elevate lower extremities as much as possible. Review of Resident #11's care plan dated 7/8/2021and last reviewed on 10/7/2021 revealed a care plan focus on skin with a description that included bilateral lower extremity edema and use of diuretics. The care plan did not include use of antiembolism stockings or elevation of the lower extremities due to congestive heart failure. Interview with the MDS Coordinator on 2/3/2022 at 3:56 PM revealed she was aware care plans had not been updated. The MDS Coordinator indicated she had been pulled to work in direct resident care. She stated resident care came first, but she acknowledged it was her responsibility to complete care plan reviews and updates every 90 days. Interview with the Director of Nursing on 2/3/2022	F 656	HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S EFFECTIVENESS: The facility Administrator will review care plans to ensure that they are comprehensive before being implemented on the unit. The facility Administrator will document the results of her review on a Quality Assurance Form and will present the results to the facility Quality Assurance Committee for review. The results will also be presented to the QAPI Committee for review to ensure that the solution is achieved, sustained, and effective. Date of compliance is 03/11/2022	

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	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 656	Continued From page 25	F 656		

at 6:26 PM revealed she expected conditions related to active treatments to be included in the care plan.

3. Resident #23 was admitted to the facility on 7/15/2021 with diagnoses of chronic obstructive pulmonary disease (COPD) requiring the use of oxygen.

Review of Resident #23's Physician orders revealed the following:
7/16/2021 - oxygen via nasal cannula at 2 liters per minute

Review of Resident #23's care plan dated 7/18/2021 and last reviewed 10/17/2021 revealed no care plan focus or interventions for COPD or the use of oxygen.

Interview with the MDS Coordinator on 2/3/2022 at 3:56 PM revealed she was aware care plans had not been updated. The MDS Coordinator indicated she had been pulled to work in direct resident care. She stated resident care came first, but she acknowledged it was her responsibility to complete care plan reviews and updates every 90 days.

Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected conditions related to active treatments to be included in the care plan.

4.Resident #30 was admitted to the facility on 3/9/21 with diagnoses which included hypertension and hyperlipidemia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 26 Review of Resident #30's quarterly Minimum Data Set (MDS) dated 11/4/21 revealed the resident was cognitively intact and independent with no assistance for majority of activities of daily living (ADL). Review of Resident #30's care plan dated 11/4/21 revealed there was no care plan for Resident #30 that addressed smoking. Review of Resident #30's Safe Smoking Evaluation dated 1/26/22 revealed Resident #30 was a safe smoker that required no supervision. The evaluation further revealed to see care plan for further details for interventions. An observation was conducted on 2/1/21 at 11:15 am revealed Resident #30 walked out the front door of the facility and smoked in a designated area unsupervised. An interview conducted with care plan coordinator on 2/2/22 at 3:30 PM revealed a smoking assessment was completed on Resident #30 on 1/26/22. The care plan coordinator further revealed Resident #30 did not have a care plan that addressed smoking. The care plan coordinator stated she was not aware Resident #30 was a smoker but would create a care plan to address Resident #30's smoking. An interview conducted with the Director of Nursing (DON) on 2/3/22 at 7:15 PM revealed Resident #30 was an unsupervised smoker but was not aware that Resident #30 was not care planned for smoking. The DON further revealed she expected for Resident #30's care plan to be updated to address smoking.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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F 656	Continued From page 27 An interview conducted with the Administrator on 2/3/22 at 7:25 PM revealed she was not aware Resident #30's care plan did not address smoking. The Administrator further revealed the MDS Coordinator who completed care plans had been pulled to assist with the facility outbreak but expected for Resident #30's care plan to address smoking.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow a physician order to apply antiembolism stockings for 2 of 2 residents (Residents #11, #31) and failed to follow a physician order to obtain daily weights for 1 of 1 resident (Resident #31) reviewed for professional standards. The findings included: 1. Resident #11 was admitted to the facility on 12/17/2019 with diagnoses of coronary artery disease and chronic congestive heart failure. a. Review of Resident #11's Physician orders revealed the following: 4/16/2020 - apply antiembolism stockings in the morning and take off in the evening. Elevate lower extremities as much as possible.	F 658	" F-658: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The order for TED hose has been discontinued for Resident #11 and Resident #31 due to resident non-compliance with wearing of the TED hose. Resident #31 did not have an order for daily weights, but Resident #11 did. Resident #11□s order for daily weights has been changed to weekly weights. All order changes have been done after discussion with the facility Attending Physician.	3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 658

Continued From page 28

Resident #11's quarterly Minimum Data Set dated 10/7/2021 revealed he was cognitively intact and required limited assistance of 1 person for dressing and personal hygiene. Resident #11 was not coded for rejection of care.

Review of Resident #11's care plan reviewed on 10/7/2021 revealed a care plan focus on skin with a description that included bilateral lower extremity edema and use of diuretics. The care plan did not include use of antiembolism stockings or elevation of the lower extremities due to congestive heart failure.

Observation of Resident #11 on 1/31/2022 at 10:12 AM while sitting in his wheelchair, revealed bilateral lower extremity edema (swelling caused by excess fluid trapped in body tissues). Resident #11 did not have antiembolism stockings on.

Review of Resident #11's Treatment Administration Record (TAR) dated 1/31/2022 through 2/3/2022 revealed the antiembolism stocking application had been signed off as completed every day.

Observation of Resident #11 on 2/1/2022 at 12:05 PM revealed he was lying in bed and was not wearing antiembolism stockings.

Observation of Resident #11 on 2/2/2022 at 9:43 AM revealed the resident sitting in his wheelchair. He was not wearing antiembolism stockings and his feet and ankles were edematous.

Interview with the Nurse Practitioner (NP) on 2/3/2022 at 11:36 AM revealed the consequences

F 658

HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:

Any resident has the potential to be affected by this practice. All resident MARs have been audited by the facility Administrative Nurse and any resident noted to have orders for TED hose and Daily weights have been checked to ensure that TED hose and weight orders are being followed as written. The facility Administrative Nurse has in-serviced all facility staff on the importance of applying TED hose and of obtaining ordered weights. The Director of Nursing has emailed all staffing agencies the facility contracts with for temporary staffing and requested that all nursing staff scheduled for Alexandria Place be in-serviced on the importance of applying TED hose and of obtaining ordered weights. The staffing agencies have been instructed to in-service their staff and have their staff sign that they have been in-serviced on this topic prior to coming to the facility to work. The staffing agencies are emailing the in-services and corresponding signature pages back to the facility to show that their staff have been in-serviced.

MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 658	Continued From page 29 of not wearing antiembolism stockings as ordered was increased edema. The NP stated she expected her orders to be followed. Telephone interview with Nurse #6 on 2/3/2022 at 2:59 PM revealed he was conssistently assigned to care for Resident #11. Nurse #6 stated he was not aware Resident #11 wore antiembolism stockings and he must have signed for the application by mistake. Interview with Nurse Aide (NA) #3 on 2/3/2022 at 3:03 PM revealed NAs were responsible for applying resident's stockings after bathing. NA #3 stated NAs did not sign for application of stockings, but Nurses were to verify stocking application and sign off for them. NA #3 stated she did not apply Resident #11's stockings because he refused. NA #3 indicated Nurses were aware the resident refused care, but she did not recall specifically informing the Nurse of the refusal of stocking application. Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected orders to be completed as written and active diagnoses with treatments to be included in the care plan. The DON stated she expected Nurses to verify application of stockings prior to signing the TAR. b. Review of Resident #11's Physician orders revealed the following: 7/22/2021 - obtain weight daily Review of the facility weight notebook revealed Resident #11 had daily weights recorded for 8/24/2021 through 8/27/2021. No further daily weights were recorded.	F 658	The facility Administrative Nurse and Medical Records Nurse will conduct audits for use of TED hose and ordered weights daily for six (6) weeks, then weekly for six (6) weeks, and then monthly thereafter to ensure that TED hose and weights are being applied/obtained as ordered. The Administrative Nurse will record the results of these audits on a Quality Assurance form and will present the form to the Quality Assurance Committee for review. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S EFFECTIVENESS: The Administrative Nurse and Medical Records Nurse will record the results of these audits on a Quality Assurance form and will present the form to the Quality Assurance Committee for review. The Quality Assurance form will also be presented to the QAPI Committee for review to ensure that the solutions are achieved and sustained. Date of compliance is 03/11/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

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ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 658	Continued From page 30	F 658		

Review of Resident #11's electronic weight change history revealed Resident #11 did not have a documented weight for 7/24/2021, 9/2/2021, 9/7/2021, 9/8/2021, 9/20/2021, 9/21/2021, 10/8/2021, 10/9/2021, 10/11/2021 through 10/13/2021, 10/15/2021, 10/19/2021 through 10/22/2021, 11/1/2021, 11/15/2021, 11/16/2021, 11/18/2021, 11/29/2021, 12/4/2021, 12/14/2021 through 12/17/2021, 12/20/2021 through 12/24/2021, 12/27/2021, 12/28/2021, 1/3/2022, 1/5/2022, 1/7/2022, 1/12/2022, 1/13/2022, 1/15/2022, 1/18/2022 through 1/21/2022, 1/16/2022 and 1/28/2022. Weights that were obtained revealed weight fluctuations between 292.4 pounds and 339 pounds.

Interview with the Nurse Practitioner (NP) on 2/3/2022 at 11:36 AM revealed the consequences of not weighing a CHF resident as ordered was that weights were used to adjust diuretic medications. The NP indicated she used a 3-pound a week weight difference to adjust diuretics (medications that help the body expel extra fluid and salts). The NP stated she expected her orders to be followed.

Interview with Medication Aide (MA) #1 on 02/03/22 at 2:54 PM revealed she completed weights in the facility. MA #1 indicated most weights were weekly, monthly, and sometimes daily. MA#1 stated she was not aware Resident #11 was to be weighed daily. MA #1 stated she was updated on new weight orders by Nursing.

Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed staff had been pulled in many directions due to the COVID outbreak and it was possible orders were missed. The DON stated she expected orders to be completed as

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	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

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F 658	Continued From page 31	F 658		

written. Any deviation from physician or NP orders should be discussed with the provider and documented in the medical record.

2. Resident #31 was admitted to the facility on 4/9/2018 with diagnoses of coronary artery disease and hypertension.

Review of Resident #31's Physician's orders revealed the following:
5/14/2020 - apply antiembolism stockings to bilateral lower extremities every morning and remove at bedtime

Review of Resident #31's annual Minimum Data Set (MDS) dated 11/82021 revealed she was moderately cognitively impaired. Resident #31 required extensive assistance of 1 person for dressing and was totally dependent on 1 person for bathing.

Review of Resident #31's care plan dated 11/8/2021 revealed no care plan or interventions related to application of antiembolism stockings. Resident #31 had no care plan for rejection of care.

Observation of Resident #31 on 1/31/2022 at 2:24 PM revealed the resident seated in a wheelchair wearing white socks, slip-on shoes and no antiembolism stockings.

Review of Resident #31's Treatment Administration Record (TAR) for 1/31/2022 through 2/3/2022 revealed the antiembolism stockings application had been signed off as applied every day.

Interview with the Nurse #3 on 2/1/2022 at 10:55

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 32	F 658		

AM revealed she performed a variety of tasks in the facility including treatments. Nurse #3 stated she was aware of the treatment order for Resident #31's application of antiembolism stockings. Nurse #3 disclosed that she did not apply Resident #31's antiembolism stockings as it was the responsibility of the hall Nurse.

Observation of Resident #31 on 2/2/2022 at 3:13 PM revealed the resident sitting in her wheelchair in the hallway with white socks and shoes on. The resident was not wearing antiembolism stockings.

Observation of Resident #31 on 2/3/2022 at 8:53 AM revealed her sitting in her wheelchair wearing pink and white socks and no antiembolism stockings.

Telephone interview with the Nurse Practitioner (NP) on 2/3/2022 at 11:36 AM revealed she did not recall Resident #31 had an order for antiembolism stockings.

Telephone interview with Nurse #6 on 2/3/2022 at 2:59 PM revealed he was consistently assigned to care for Resident #31. Nurse #6 stated he was not aware Resident #31 wore antiembolism stockings. Nurse #6 stated he had signed for application of the stockings in error.

Interview with Nurse Aide (NA) #3 on 2/3/2022 at 3:03 PM revealed NAs were to apply antiembolism stockings after bathing residents and Nurses were responsible for verifying and signing for the application. NA #3 stated she did not apply Resident #31's stockings because it agitated the resident. NA #3 did not recall specifically telling a Nurse that the stockings were

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F 658	Continued From page 33 not applied. Telephone interview with Nurse #7 on 2/3/2022 at 3:21 PM revealed Resident #31 refused care at times. Nurse #7 stated re-approaching Resident #31 for cooperation most often resulted in completion of care. Interview with the Director of Nursing (DON) on 2/3/2022 at 6:26 PM revealed she expected orders to be completed as written and active diagnoses with treatments to be included in the care plan. The DON stated she expected Nurses to verify application of stockings prior to signing the TAR.	F 658		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, Nurse Practitioner, and Wound Physician interviews, the facility failed to complete skin assessments as ordered, effectively assess, and	F 686	" F-686: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686

Continued From page 34

monitor a pressure ulcer, and ensure treatments were ordered by the Nurse Practitioner in accordance with the treatment plan (Resident #106). Resident #106 was hospitalized on 12/22/21 with a stage 4 pressure ulcer (full-thickness skin and tissue loss) with tunneling (passageway of tissue destruction under the skin surface). The facility also failed to provide pressure ulcer care as ordered by the physician (Resident #44). This was for 2 of 3 residents reviewed for pressure ulcers (Residents #106 and #44).

Immediate jeopardy began on 12/19/21 when the facility failed to provide the necessary care and services for a pressure ulcer that deteriorated in condition. The immediate jeopardy was removed on 02/13/22 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 was cited at a scope and severity level of "D".

The findings included:

1. Resident #106 was admitted to the facility on 09/21/13 with diagnoses which included congestive heart failure, peripheral vascular disorder, type II diabetes mellitus, dementia, and chronic pain syndrome.

Resident #106's quarterly Minimum Data Set dated 10/07/21 revealed she was moderately cognitively impaired and required extensive assistance of 2 staff with bed mobility, transfers

F 686

AFFECTED BY THE DEFICIENT PRACTICE:

Resident #106 is no longer a resident at Alexandria Place and therefore, no interventions are needed for Resident # 106.

HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:

Alexandria Place has identified that any residents have the potential to be affected by this practice.

The facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all skin assessments, wound dressing changes, and notifications to the Attending Physician. This Administrative Licensed Practical Nurse has been in-serviced on 02/11/2022 and assisted the Director of Nursing and two Nurse Managers in completing skin audits and order audits for all residents on 02/11/2022. An outside facility consultant conducted the in-service of the Administrative Licensed Practical Nurse and also in-serviced the Director of Nursing and two Nurse Managers as well. The results of the audit showed that all residents receiving wound treatments are

F 686 Continued From page 35

and toileting. The MDS further revealed Resident #106 was always incontinent of bowel and bladder and at risk for developing pressure ulcers but had none at present. The MDS indicated Resident #106 had a pressure reducing device on her bed. There were no documented behaviors reflected in the MDS.

Resident #106's care plan dated 10/07/21 revealed a plan of care for pressure ulcers. The care plan stated Resident #106 had diagnoses of Alzheimer's disease, dementia, congestive heart failure and lymphedema. She was noted with a history of pressure ulcers. She was incontinent of bladder and bowel. Staff assists with toileting and peri care frequently and as needed (prn). She required extensive to total assistance with activities of daily living (ADL) and transfers. Resident #106 was at risk for skin breakdown. The interventions included provide supplemental nutritional support, monitor labs as ordered, weekly skin assessments per facility protocol, encourage good nutritional intake, maintain pressure reduction mattress to bed, provide incontinence care frequently and as needed, monitor skin daily during morning care and treatments as ordered. There was no documented care plan for refusal of care.

Resident #106's skin assessment dated 10/17/21 read in part "no issues with skin, skin warm, dry and intact." Further review of the record revealed there was no evidence of any skin assessments completed, signed, and dated from 10/18/21 through 12/07/21.

Resident #106's skin assessment dated 12/08/21 read in part "resident would not let nurse check skin that isn't visible. States she had no open

F 686

currently receiving the correct treatment and that no new skin issues exist.

The facility has also in-serviced all staff that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Unit Nurse, Administrative Licensed Practical Nurse, Nurse Managers, or Director of Nursing of any skin breakdown or skin integrity issues. The unit nurses have been in-serviced on the proper way to assess, document, and notify the physician of any skin issues that may be brought to their attention by the CNAs. CNAs were in-serviced on what to do to prevent pressure ulcers, notifying the nurse of resident refusals of turning and repositioning, notifying nurses of resident refusals to get out of bed, and what skin changes they need to watch for and to report these to the unit nurse. These in-services were conducted by an outside facility consultant and included the Director of Nursing as a participant. The Director of Nursing will continue to in-service all staff 02/11/2022 02/12/2022 to ensure that all staff have received in-servicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be in-serviced at the start of their shift to ensure that they are aware of the facility's protocol and what to do in the event that a skin issue appears during their shift.

The Nurse Practitioner has been in-serviced by the facility Administrator on the proper protocol for writing orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686

Continued From page 36

areas on her body. No skin issues observed on skin visible." The note was signed by Nurse #2 who had attempted the skin assessment. There were no progress notes or documentation that indicated Nurse #2 attempted the skin assessment later that day.

Resident #106's nursing progress note dated 12/09/21 at 4:33 AM, read in part, "weekly nursing evaluation completed. Resident would not let nurse check skin that isn't visible, resident stated she has no open areas on her body. No skin issues/abnormalities observed on visible skin during nursing evaluation. Resident remains stable, no s/s distress or discomfort, continues scheduled pain medication with no breakthrough pain." Written by Nurse #5 as part of the weekly nursing evaluation.

An interview on 02/02/22 at 11:41 AM with Nurse Aide (NA) #1 revealed she had taken care of Resident #106 on 12/09/21 and reported to Nurse #2 that her skin was red on her buttocks and coccyx area, and she had several areas that looked raw and were red. She stated there were areas on the back of her legs and her bottom and coccyx area. NA #1 stated this was the first day she had noticed her buttocks being red.

An interview on 02/03/22 at 5:30 PM with Nurse #1 assigned to Resident #106 on 12/09/21 revealed she had been called into the shower room by the Nurse Aide (could not recall her name) caring for the resident on 12/09/21 to look at her bottom. Nurse #1 stated she went into the shower room to see Resident #106's bottom and described the resident was moaning and groaning and said she had several different areas on her bottom and coccyx with one area that

F 686

notifying the Nursing Staff of any change in orders. She has also been informed that she is to follow all wounds on a weekly basis or more often if needed and is to report off to the Director of Nursing and Administrator any changes in wounds or wound orders. This report will be made in writing. The facility Administrator has established a new protocol whereby any wound stage II or greater will automatically be referred to the Wound Care Physician. The Administrator contacted the Wound Care Physician, the Attending Physician, and Attending Nurse Practitioner on 02/11/2022 and has informed each of them of the protocol for writing orders and notifying the staff of any change in orders.

All residents that have wounds have now been referred to the facility□s contract wound care physician by the Administrative Licensed Practical Nurse for follow up and treatment even if they are managed care clients and have a nurse practitioner experienced in wound care. All current residents with wounds have been referred to the contract wound care physician on 02/11/2022 if they were not already being seen by this physician. The contract wound care physician makes weekly visits and will assess wounds weekly. The Administrative Licensed Practical Nurse will accompany the contract wound care physician on his visits to ensure that any needed treatment changes are properly ordered and entered into the resident□s chart. In the event that the Administrative Licensed Practical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

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F 686

Continued From page 37

resembled a blister with fluid in it. Nurse #1 further stated she followed the standing orders and completed treatment of cleaning the areas with wound cleanser and applying a foam dressing to the areas. She said she was not aware she was supposed to complete a wound assessment on Resident #106 and said no one had shown her how to do that at the facility. Nurse #1 indicated she had placed a note in the provider book for the Nurse Practitioner to see the resident on her next round. Nurse #1 said she had done the dressing on the resident several times and stated her wound was not getting better and had gotten worse. Nurse #1 indicated the resident was noncompliant with turning and repositioning to offload her buttock and coccyx area and wouldn't allow the staff to assist her in turning and repositioning. She further indicated the resident had refused her meals several times and refused to get up out of bed to assist in offloading her buttocks and coccyx. Nurse #1 stated she had tried to talk the resident into repositioning and tried to talk her into getting up in her chair but Resident #106 still refused to get up.

A physician's order for Resident #106 written on 12/09/21 read: "cleanse area to left buttock with wound cleanser, pat dry, apply absorbent foam dressing) and change every 3 days and as needed until resolved. Cleanse area to back of upper leg with wound cleanser, pat dry and apply absorbent foam dressing and change every 3 days and as needed until resolved. Cleanse area to coccyx with wound cleanser, pat dry, apply absorbent foam dressing and change every 3 days and as needed until resolved. Complete weekly skin assessments."

F 686

Nurse is not available to conduct skin assessments, do dressing changes, or to accompany the contract wound care physician, one of the Nurse Managers will fulfill those duties.

MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:

The facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all skin assessments, wound dressing changes, and notifications to the Attending Physician. This Administrative Licensed Practical Nurse has been in-serviced on 02/11/2022 and assisted the Director of Nursing and two Nurse Managers in completing skin audits and order audits for all residents on 02/11/2022. An outside facility consultant conducted the in-service of the Administrative Licensed Practical Nurse and also in-serviced the Director of Nursing and two Nurse Managers as well. The results of the audit showed that all residents receiving wound treatments are currently receiving the correct treatment and that no new skin issues exist.

The facility has also in-serviced all staff that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Unit Nurse, Administrative Licensed Practical Nurse, Nurse Managers, or Director of Nursing of any skin breakdown or skin integrity issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 686

Continued From page 38

A Nurse Practitioner (NP) progress note dated 12/10/21 revealed the resident was being seen for "follow up visit for evaluation of buttocks breakdown." Integumentary (includes the skin and all its layers) was noted as being positive for poor healing of wounds. The wounds were described in the notes as "multiple denuded (stripped of covering) areas with top layer of skin sheared off over bilateral upper/posterior thighs, buttocks, and coccyx." Resident #106 was diagnosed by the NP with "non-pressure chronic ulcer of buttock limited to breakdown on skin." The plan was to "continue to cleanse area with wound cleanser and apply bordered foam dressing daily and as needed. Notify if areas worsen or stall in healing process." The contingency plan was "consider temporary indwelling urinary catheter if skin condition declines."

A review of the physician's orders for Resident #106 revealed there was no order written to change the frequency of treatments to daily from every 3 days.

A phone interview with the Nurse Practitioner (NP) on 02/01/22 at 3:12 PM revealed she saw the resident on 12/10/21 and she had multiple denuded areas of sheared skin on her buttocks and coccyx area. During the conversation with the NP, she referred to the wound as a pressure wound not a non-pressure chronic ulcer of the buttocks as she had noted in her progress notes on 12/10/21. She stated she had written in Resident #106's treatment plan on her progress note dated 12/10/21 to clean the areas with wound cleanser and apply antibiotic cream and cover with a foam dressing daily and as needed. The NP acknowledged that she had not written

F 686

The unit nurses have been in-serviced on the proper way to assess, document, and notify the physician of any skin issues that may be brought to their attention by the CNAs. CNAs were in-serviced on what to do to prevent pressure ulcers, notifying the nurse of resident refusals of turning and repositioning, notifying nurses of resident refusals to get out of bed, and what skin changes they need to watch for and to report these to the unit nurse. These in-services were conducted by an outside facility consultant and included the Director of Nursing as a participant. The Director of Nursing will continue to in-service all staff 02/11/2022 □ 02/12/2022 to ensure that all staff have received in-servicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be in-serviced at the start of their shift to ensure that they are aware of the facility□s protocol and what to do in the event that a skin issue appears during their shift.

The Nurse Practitioner has been in-serviced by the facility Administrator on the proper protocol for writing orders and notifying the Nursing Staff of any change in orders. She has also been informed that she is to follow all wounds on a weekly basis or more often if needed and is to report off to the Director of Nursing and Administrator any changes in wounds or wound orders. This report will be made in writing. The facility Administrator has established a new protocol whereby any wound stage II or greater will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686 Continued From page 39

orders for the treatment in the physician orders but should have so the nurses would have known the frequency and how to perform the care for Resident #106's pressure ulcer. The NP described Resident #106 as arousable but said she didn't communicate a lot with her. She described her appetite as waxing and waning and said she was immobile during the time she had her wounds and was not motivated to offload while in the bed and was refusing to turn while in the bed and refusing to get up. The NP said given her comorbidities and overall generalized decompensated condition she stated Resident #106's wounds were unavoidable, and she also said she would have expected her wounds to have gotten worse. The NP indicated the wounds could have been a source of her pain, but the resident had been diagnosed with chronic pain. The NP further indicated although she would have anticipated her wounds to have gotten worse given her overall poor health, she would have expected the nurses to have notified her of the worsening of the wound and she would have re-evaluated her wounds and possibly ordered a urinary catheter to be placed. According to the NP she had not referred Resident #106 to the wound physician because she had previous experience with wounds and worked in a wound clinic and felt while the wound was a stage II she could manage and treat it but stated had she known the wound had gotten worse she would have referred Resident #106 to the wound physician.

Review of Resident #106's Treatment Administration Record (TAR) for December 2021 revealed the following order: Cleanse area to coccyx with wound cleanser, pat dry, apply Allevyn (foam dressing that removes fluid faster

F 686

automatically be referred to the Contract Wound Care Physician. The Administrator contacted the Contract Wound Care Physician, the Attending Physician, and Attending Nurse Practitioner on 02/11/2022 and has informed each of them of the protocol for writing orders and notifying the staff of any change in orders.

All residents that have wounds have now been referred to the facility's contract wound physician by the Administrative Licensed Practical Nurse for follow up and treatment even if they are managed care clients and have a nurse practitioner experienced in wound care. All current residents with wounds have been referred to the contract wound physician on 02/11/2022 if they were not already being seen by this physician. The contract wound care physician makes weekly visits and will assess wounds weekly. The Administrative Licensed Practical Nurse will accompany the contract wound care physician on his visits to ensure that any needed treatment changes are properly ordered and entered into the resident's chart. In the event that the Administrative Licensed Practical Nurse is not available to conduct skin assessments, do dressing changes, or to accompany the contract wound care physician, one of the Nurse Managers will fulfill those duties.

Additionally, the Director of Nursing will review all skin assessments weekly for six (6) weeks, bi-weekly for six (6) weeks, and monthly for six (6) months to insure that skin assessments are completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 40 than regular dressings) and change every 3 days and as needed until resolved. Effective date of the order was 12/09/21. The TAR from 12/9/21 through 12/18/21 revealed that treatments were provided as ordered every 3 days on 12/09/21, 12/12/21, 12/15/21, and 12/18/21. There were no PRN treatments documented as provided. The medical record revealed no evidence of any pressure ulcer assessments completed for Resident #106's stage II pressure ulcer after the NP's evaluation on 12/10/21. Further review of the medical record revealed no evidence wound measurements were obtained after the pressure ulcer was first identified on 12/9/21. An interview on 02/02/22 at 11:49 AM with Nurse Aide (NA) #2 revealed she had taken care of Resident #106 on 12/19/21 and had asked the Director of Nursing (DON) to come into her room to look at the residents wound. NA #2 stated the wound was red with some bleeding in some areas and there were areas of black on the wound. The NA stated she could not remember the wound having a foul odor but said it could have and she just didn't remember. NA #2 stated the wound looked worse than the last time she had seen it and taken care of the resident on 12/15/21. An interview on 02/03/22 at 6:42 PM with the Director of Nursing (DON) revealed she had been at the facility on 12/19/21. The DON stated she had been asked by the NA (could not recall her name) taking care of the resident on 12/19/21 to come into the room and look at her wounds while she was performing incontinence care. The DON stated she went into the room and looked at the wounds on her buttocks and coccyx and stated	F 686	The Director of Nursing will document her reviews of documentation on a Quality Assurance form and will present this form to the Quality Assurance Committee for review. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED The Director of Nursing�s Quality Assurance checks will also be reviewed by the QAPI Committee to ensure that the solution is achieved, effective, and sustained. The Director of Nursing�s Quality Assurance checks will also be reviewed by the QAPI Committee to ensure that the solution is achieved, effective, and sustained. Date of compliance is 03/11/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

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F 686	Continued From page 41 the pressure ulcer had worsened and appeared as though the wound was tunneling. She said she called the Unit Manager at home to ask her about the wound and care of the wound. The DON indicated she did the wound care as ordered and had placed a note in the provider book for the NP to see the resident on her next rounds. The DON further indicated she should have completed an assessment of the wound but had not done so and could not remember why she had not documented her observation of the wounds. She said she should have completed a wound assessment with measurements for the NP to review on her next rounds at the facility. The DON explained the NP was at the facility 3 days per week and available by phone as needed. The facility was unable to locate the note that was placed in the provider book by the DON on 12/19/21. A nursing progress note dated 12/21/21 written at 7:15 AM by Nurse #2 revealed "NA came to get nurse to show wounds on bottom. No dressings on bottom. Two (2) absorbent foam dressings placed on buttocks. Wound communication put in provider book." The note was placed in the provider book for the NP to see the resident on her next rounds in the facility. A phone interview was attempted on 02/02/22 at 11:30 AM, 02/03/22 at 9:26 AM, and 02/03/22 at 3:31 PM with Nurse #2 with no return call. The facility was unable to locate the note that was placed in the provider book by Nurse #2 on 12/21/21.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 42	F 686		

A nursing progress noted dated 12/22/21 written at 6:38 PM by Nurse #5 revealed Resident #106 was "observed not in her baseline orientation this morning. Not able to respond to commands, not able to stick her tongue out. No grasp reflex. Not her usual self. DON notified for comparison to normal baseline. Directed from DON to call family and ask if they wanted resident sent out. Family member requested send to emergency department for further evaluation. On call contacted. NP gave order to send to ED (emergency department) to rule out possible transient ischemic attack (TIA)/stroke. Vital signs 107/65, 105, 99.0, 97% and blood sugar 127."

A phone interview was attempted on 02/02/22 at 11:31 AM, 02/03/22 at 9:28 AM and 02/03/22 at 3:33 PM with Nurse #5 with no return call.

Resident #106's hospital admission notes revealed she was admitted to the local hospital on 12/22/21 through the emergency department (ED) to the ICU (Intensive Care Unit). The resident was evaluated for generalized weakness and altered metal status. The resident had a decubitus ulcer that was undergoing treatment at the facility where she resided. The resident was diagnosed with acute kidney injury, hepatic encephalopathy, hypernatremia, lactic acidosis, respiratory failure, and sacral wound. The resident had a large foul-smelling decubitus ulcer that would likely require surgical evaluation and possibly debridement. She was admitted her for further management and stabilization to the critical care unit. The resident was initiated on broad-spectrum antibiotics for her sepsis, and it was suspected the wound was the source of her infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD** **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 686	Continued From page 43 A phone interview was attempted with the attending hospital physician on 02/03/22 at 11:30 AM, 02/03/22 at 2:00 PM and 02/03/22 at 4:00 PM with no return call. An interview on 02/03/22 at 6:42 PM with the DON revealed there should have been weekly skin assessments documented for Resident #106 especially since she had developed a stage II decubitus ulcer on 12/09/21. She stated she contributed some of the breakdown to the agency staff in the building. The DON further stated she was planning to implement bedside rounding so the nurses were looking at the residents while giving report. She indicated they had already revamped their 24-hour reporting sheets to include labs and x-ray reports so the nurses would be aware of any pending labs or reports. The DON further indicated since they were using so much agency, she had started bringing them in on meetings monthly and had included them on group texts. The DON said she couldn't explain why Resident #106's weekly skin assessments had not been done and stated there were always opportunities to view a resident's skin during incontinence care, showers, baths and when dressing. She also said the nurses should have asked for assistance with the skin assessments if they were unable to get the resident to allow them to look at her skin. The DON stated she realized they were going to need to provide additional education to the NAs and the nurses about skin assessments and wound care. She further stated she was planning to ask the wound doctor if he could provide some education to the NAs and the nurses regarding wounds. According to the DON, she expected skin assessments to be completed by the nurses, orders for wound care to be written by the providers and wound care to be done by	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD 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 686	Continued From page 44	F 686		

the nurses as ordered by the physician. Additionally, the DON stated they would be doing some education with the Nurse Practitioner regarding the process for writing orders. The DON stated their normal process for verbal or written orders were for them to be written on the physician order sheets not in the treatment plan on progress notes. She indicated the NP notes were not immediately available in the resident's record so she would need to write any orders she wanted carried out in the physician order section of the resident's medical record.

An interview with the Administrator on 02/03/22 at 7:32 PM revealed she had just taken over the building as the Administrator in the middle of December 2021. She stated she quickly found out there were systems that were not in place that needed to be in place. She indicated she expected skin assessments and wound care to be done as ordered and stated it should have been done all along for the residents.

The nursing home President and owner was notified of Immediate Jeopardy on 02/10/22 at 5:05 PM

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

The facility has identified that the use of Staffing Agency personnel and the actions of the Nurse Practitioner led to a breakdown in the system for reporting skin issues, initiating treatments, effectively assessing, and monitoring identified skin issues, and notification of the resident's Attending Physician as well as the failure to complete weekly skin assessments. The use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 45	F 686		

multiple Staffing Agency personnel resulted in weekly skin assessments not being completed by Agency nurses and in a failure to report skin issues by the agency CNAs. Alexandria Place has also identified that the Nurse Practitioner failed to actually write the order to change the dressing from every three days to daily or to notify facility staff of her desire to change the order. The Nurse Practitioner included in her progress noted of 12/10/2021 the change in order but failed to write an order as is the facility's system or to notify anyone in Nursing of the need to change the order. The Nurse Practitioner also failed to follow the wound herself and therefore failed to note that a change in dressing order had not been done. The facility does not receive the Nurse Practitioner's dictated progress notes until a full week to two weeks after the note is dictated and was not aware of the Nurse Practitioner's order to change the frequency of the wound dressing. These issues led to Resident #106's wound order not being changed and to the deterioration of the wound not being noted timely.

The Director of Nursing was not aware that the Nurse Practitioner had not been notified of the worsening of the wound and was not aware that skin assessments, wound assessments, or measurements had not been done. The Director of Nursing did not complete these tasks herself because she thought the floor staff had completed them. The missing note from the provider book has not been found.

Resident #106 is no longer a resident at Alexandria Place and therefore, no interventions are needed for Resident # 106.

Alexandria Place has identified that all residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 46 have the potential to be affected by this practice. 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 facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all skin assessments, wound dressing changes, and notifications to the Attending Physician. This Administrative Licensed Practical Nurse has been inserviced on 02/11/2022 and assisted the Director of Nursing and two Nurse Managers in completing skin audits and order audits for all residents on 02/11/2022. An outside facility consultant conducted the inservice of the Administrative Licensed Practical Nurse and also inserviced the Director of Nursing and two Nurse Managers as well. The results of the audit showed that all residents receiving wound treatments are currently receiving the correct treatment and that no new skin issues exist. The facility has also inserviced all staff that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Unit Nurse, Administrative Licensed Practical Nurse, Nurse Managers, or Director of Nursing of any skin breakdown or skin integrity issues. The unit nurses have been inserviced on the proper way to assess, document, and notify the physician of any skin issues that may be brought to their attention by the CNAs. CNAs were inserviced on what to do to prevent pressure ulcers, notifying the nurse of resident refusals of turning and repositioning, notifying nurses of resident refusals to get out of bed, and what skin changes they need to watch	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

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F 686	Continued From page 47	F 686		

for and to report these to the unit nurse. These inservices were conducted by an outside facility consultant and included the Director of Nursing as a participant. The Director of Nursing will continue to inservice all staff 02/11/2022 - 02/12/2022 to ensure that all staff have received inservicing on the proper protocols. Any new agency staff that may be coming to the facility in the future will be inserviced at the start of their shift to ensure that they are aware of the facility's protocol and what to do in the event that a skin issue appears during their shift.

The Nurse Practitioner has been inserviced by the facility Administrator on the proper protocol for writing orders and notifying the Nursing Staff of any change in orders. She has also been informed that she is to follow all wounds on a weekly basis or more often if needed and is to report off to the Director of Nursing and Administrator any changes in wounds or wound orders. This report will be made in writing. The facility Administrator has contacted the Wound Physician, the Attending Physician, and Attending Nurse Practitioner on 02/11/2022 and has informed each of them of the protocol for writing orders and notifying the staff of any change in orders.

All residents that have wounds will also now be referred to the facility's contract wound service by the Administrative Licensed Practical Nurse for follow up and treatment even if they are managed care clients. Any current resident with wounds will be referred to the contract wound service on 02/11/2022 if they are not already being seen by this service. The Administrative Licensed Practical Nurse will accompany the wound physician on their visits to ensure that any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 48	F 686		

dressing changes are properly ordered and entered into the resident's chart. In the event that the Administrative Licensed Practical Nurse is not available to conduct skin assessments, do dressing changes, or to accompany the wound physician, one of the Nurse Managers will fulfill those duties.

Date of alleged Immediate Jeopardy Removal: 2/13/2022. Person responsible for the implementation is the Administrator.

On 02/17/22 the facility's credible allegation was validated through record reviews, staff, and resident interviews. The facility provided education documentation for all staff on identifying and reporting a change in condition especially in skin integrity. In addition, the facility provided signed education sheets on the new system for completing skin assessments. The education provided detailed how all new admissions, readmissions would have an initial, weekly, and as needed skin assessments completed by the nurse. Interviews conducted with the nursing staff validated skin assessments were assigned to each resident and were flagged on the Medication Administration Record (MAR) for the nurse to complete. The nurses interviewed were able to explain with accuracy the new system implemented by the facility.

Nursing Assistants were interviewed and described the new system of describing any changes in the residents' skin on their shower sheets and demonstrated a copy of the sheet and how they were taught to mark any changes in the resident's skin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 49	F 686		

The Director of Nursing (DON) was interviewed and described the way the new system to ensure skin assessments were completed. She reported all skin assessments were assigned in the electronic medical record (EMR) on the Medication Administration Record (MAR) to be completed by the nurse on the resident's scheduled shower day. She explained she or her designee were responsible for reviewing the assessments daily to ensure all skin assessments had been thoroughly completed. The DON explained she or her designee verified the sheets were completed in detail and not just "checked" as done.

The Administrator was interviewed and described in detail her education with the Nurse Practitioner (NP), Facility Medical Director and Wound Physician regarding referral of all wounds to the Wound Physician and collaboration between the NP, Medical Director and Wound Physician regarding resident wounds.

A resident identified by the facility as alert and oriented with a wound was interviewed and reported his skin was assessed weekly by the nurse and nurse aide during his showers and he was followed by the Wound Physician for his decubitus ulcer.

The credible allegation for the immediate jeopardy removal was validated on 02/17/22 with a removal date of 02/13/22.
2. Resident #44 was admitted to the facility on 9/17/21 with diagnoses that included congestive heart failure, adult failure to thrive, fracture of left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 50	F 686		

humerus (arm bone between shoulder and elbow) and stage 2 pressure ulcer of left buttock.

The Care Area Assessment for Pressure Ulcer on the admission Minimum Data Set (MDS) assessment dated 9/24/21 indicated Resident #44 had limited mobility and required extensive to total assist with activities of daily living and transfers. She was admitted with an existing pressure ulcer and fracture. She utilized a pressure reduction mattress. Resident #44 was at risk for skin breakdown.

A review of Resident #44's Weekly Skin Assessment dated 12/15/21 indicated a rash to the right shoulder, redness to left chest underneath breast area, a shear wound to the left buttock and a purple discoloration to the distal side of the left heel.

Resident #44's Wound Assessment Report dated 12/16/21 indicated a new pressure ulcer to the left heel was identified on 12/15/21. It was described as unstageable due to slough/eschar (dead tissue) with the following measurements: length-1.8 cm (centimeters), width-1.8 cm and depth-0 cm.

The most recent quarterly MDS assessment dated 12/17/21 indicated Resident #44 was cognitively intact, required extensive physical assistance with all activities of daily living and had impairment on one side of the upper extremities. She had one unstageable pressure ulcer due to slough/eschar present and continued to have a pressure reducing device for bed.

Resident #44's care plan reviewed on 12/17/21 indicated the following interventions under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686 Continued From page 51 F 686

pressure ulcers: refer to wound specialist as needed, treatments as ordered, weekly skin assessment per facility protocol and maintain pressure reduction mattress.

A review of a physician order dated 1/24/22 indicated to cleanse wound to left heel with wound cleanser, pat dry, apply (antimicrobial gel) and (collagenase ointment), then gauze, then (foam heel cup), wrap with (bandage roll) and change daily.

a. An observation of pressure ulcer care on Resident #44 was made on 2/2/22 at 9:41 AM of Nurse #3. Nurse #3 cleaned the wound to the left heel with a gauze soaked with wound cleanser. She applied a mixture of an antimicrobial gel and collagenase ointment to the surface of the wound using a cotton swab applicator. Nurse #3 covered the wound with a petrolatum gauze, applied a foam heel cup and wrapped it with a bandage roll. The pressure ulcer to the side of the left heel had the following approximate measurements: length-1 cm, width-1cm, depth-0.5 cm. The wound bed was clean with 80% granulation tissue observed surrounded by rough and peeling edges.

A phone interview with Nurse #3 on 2/2/22 at 1:10 PM revealed she got confused with the order for Resident #44's left heel pressure ulcer. Nurse #3 explained that she followed a printout with step-by-step directions and items needed to perform the treatment. The printout included a petrolatum gauze but when she verified the order in the electronic medical record after she performed the procedure, she saw the order did not include the use of a petrolatum gauze. Nurse #3 further stated she called the Unit Manager to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 52	F 686		

ask her if it was acceptable to use a petrolatum gauze instead of a regular gauze which was specified in the order. The Unit Manager told her that she was going to check with the wound doctor and clarify the order for Resident #44's left heel pressure ulcer.

An interview with the Unit Manager (UM) on 2/2/22 at 3:00 PM revealed she frequently rounded with the wound doctor whenever he came to the facility. The UM confirmed that the last time the wound doctor assessed Resident #44's left heel pressure ulcer, he changed the treatment order from using a petrolatum gauze to collagenase ointment and regular gauze because the wound needed more debridement and he preferred using collagenase for this purpose. The treatment orders were located in the electronic medical record, but the UM also made a book of printouts that had step by step instructions to help the nurses when they performed wound care. The UM reported that Nurse #3 had asked her about the petrolatum gauze after she did Resident #44's treatment to her left heel pressure ulcer and told her she got confused because the printout still had a petrolatum gauze listed as one of the items needed but she failed to read the instructions that only included a regular gauze. The UM stated she told Nurse #3 she should have looked at the Treatment Administration Record in the electronic medical record and not relied on the printout. The UM also stated Nurse #3 should have used a regular gauze instead of a petrolatum gauze.

An interview with the wound doctor on 2/3/22 at 10:44 AM revealed he had been following Resident #44 for over 2 months and had been treating her left heel pressure ulcer. It started as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 53	F 686		

a deep tissue injury with unstageable necrosis which he debrided and eventually advanced the staging to stage 4 due to exposure of fascia 2-3 weeks after it was first identified. At some point he had ordered the use of petrolatum gauze because the wound was too dry, and it needed moisture, but he discontinued it on 1/24/22 and changed the treatment to an antibiotic gel and collagenase ointment because it needed debridement. The wound doctor stated Nurse #3 probably did not pick up on the change in the treatment and used petrolatum gauze instead of a regular gauze which might not have been harmful, but it added a lot of moisture to the wound and could cause maceration of the surrounding skin tissue. The wound doctor also stated he expected the nurses to follow his orders and instructions when providing pressure ulcer care to Resident #44.

An interview with the Director of Nursing (DON) on 2/3/22 at 6:22 PM revealed Nurse #3 should not have relied on the printout and should have looked at the order on the electronic medical record before doing Resident #44's dressing change. The DON stated she had addressed the issue with the UM and instructed her to do away with the book or at least make a copy of the current order and continually update it to reflect the current treatment orders.

b. A review of Resident #44's Treatment Administration Record (TAR) for January 2022 indicated the treatment order for Resident #44's left heel was left blank on 1/15/22 and 1/31/22.

An interview with Nurse #4 on 2/3/22 at 2:20 PM revealed she took care of Resident #44 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD 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 686	Continued From page 54	F 686		

1/15/22 and did not remember doing the treatment to her left heel. Nurse #4 stated she had just come off orientation around that time, but she could not remember why she didn't do Resident #44's dressing change to the left heel. Nurse#4 confirmed that if she didn't mark it off as completed in her TAR, she didn't do the treatment.

An interview with Nurse #1 on 2/3/22 at 3:35 PM revealed she was supposed to do all the treatments on 1/31/22 but she got pulled to work on a hall when a nurse had to go home. Nurse #1 stated she took over the medication cart around 9:00 AM and got behind doing the medication pass. Nurse #1 said that with everything that went on that day, she didn't have time to do the treatments and she thought someone else was assigned to do them.

An interview with the Unit Manager on 2/3/22 at 3:33 PM revealed she was not aware who had been assigned to do the treatments on 1/31/22 and thought the nurses on the halls were supposed to do them.

An interview with the Director of Nursing on 2/3/22 at 6:22 PM revealed it was not acceptable that treatments and dressing changes were not getting completed as ordered. The DON stated part of the problem was having agency nurses who didn't even realize that there were treatment records that they needed to review and complete. She further stated that there had been a breakdown in communication and had encouraged the nurses to do bedside rounding and revamped their 24-hour reports to include more information that should be shared between shifts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 686	Continued From page 55 An interview with the Administrator on 2/3/22 at 7:19 PM revealed she had been aware of issues with wound care not being done according to physician orders because the unit managers had been getting pulled to help with scheduling and weren't able to do their job. Audits were not being done and with the use of agency staff, she acknowledged that care was not where it needed to be.	F 686		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 842	Continued From page 56	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 842	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain an accurate Treatment Administration Record (TAR) for 2 of 2 residents (Resident #11 and #31) reviewed for application of antiembolism stockings. The findings included: 1a. Resident #11 was admitted to the facility on 12/17/2019 with diagnoses of coronary artery disease and chronic congestive heart failure. Review of Resident #11's Physician orders revealed the following: 4/16/2020 - apply antiembolism stockings in the morning and take off in the evening. Elevate lower extremities as much as possible. Observation of Resident #11 on 1/31/2022 at 10:12 AM while sitting in his wheelchair, revealed bilateral lower extremity edema (swelling caused by excess fluid trapped in body tissues). Observation of Resident #11 on 2/1/2022 at 12:05 PM revealed he was lying in bed and was not wearing antiembolism stockings. Observation of Resident #11 on 2/2/2022 at 9:43 AM revealed the resident sitting in his wheelchair. He was not wearing antiembolism stockings and his feet and ankles were edematous. Observation of Resident #11 on 2/2/2022 at 9:43 AM revealed the resident sitting in his wheelchair. He was not wearing antiembolism stockings and his feet and ankles were edematous.	F 842	" F-842: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The nurse that signed the Treatment Administration Record for Resident #11 and Resident #31 has been counseled with concerning signing for medications and/or treatments without first verifying that the medications/treatments have been administered. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident has the potential to be affected by this practice. The nurse that signed the Treatment Administration Record for Resident #11 and Resident #31 has been counseled with and in-serviced on 03/11/2022 concerning signing for medications and/or treatments without first verifying that the medications/treatments have been administered. MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 842

Continued From page 58

Review of Resident #11's TAR revealed staff had signed off that antiembolism stockings had been applied each morning and removed each evening from 1/31/2022 through 2/2/2022.

Telephone interview with Nurse #6 on 2/3/2022 at 2:59 PM revealed he was consistently assigned to care for Resident #11. Nurse #6 stated he was not aware Resident #11 wore antiembolism stockings. Nurse #6 indicated he had signed the TAR in error for application of the stockings.

Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected Nurses to verify completion of treatments prior to signing the TAR.

2. Resident #31 was admitted to the facility on 4/9/2018 with diagnoses of coronary artery disease and hypertension.

Review of Resident #31's Physician's orders revealed the following:
5/14/2020 - apply antiembolism stockings to bilateral lower extremities every morning and remove at bedtime.

Observation of Resident #31 on 1/31/2022 at 2:24 PM revealed the resident seated in a wheelchair wearing white socks, slip-on shoes and no antiembolism stockings.

Observation of Resident #31 on 2/2/2022 at 3:13 PM revealed the resident sitting in her wheelchair in the hallway with white socks and shoes on. The resident was not wearing antiembolism stockings.

F 842

DOES NOT RECUR:

All facility nurses have been in-serviced by the Director of Nursing and Administrative Nurse on the importance of accurately documenting on the Medication Administration and Treatment Administration Records. The Director of Nursing has emailed all agencies the facility contracts with for temporary staffing and request that all nursing staff scheduled for Alexandria Place be in-serviced on the importance of accurately documenting on the Medication Administration and Treatment Administration Records.The staffing agencies have been instructed to in-service their staff and have their staff sign that they have been in-serviced on this topic prior to coming to the facility to work. The staffing agencies are emailing the in-services and corresponding signature pages back to the facility to show that their staff have been in-serviced. The facility Administrative Nurse will conduct audits of resident charts daily for six (6) weeks, then weekly for six (6) weeks, and then monthly thereafter to ensure that facility and agency nurses are accurately documenting on the Medication Administration and Treatment Administration Records. The Administrative Nurse will record the results of these audits on a Quality Assurance form and will present the form to the Quality Assurance Committee for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD GASTONIA, NC 28054**

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F 842	Continued From page 59 Observation of Resident #31 on 2/3/2022 at 8:53 AM revealed her sitting in her wheelchair wearing pink and white socks and no antiembolism stockings. Review of Resident #31's TAR for 1/31/2022 through 2/3/2022 revealed the antiembolism stockings application had been signed off as completed every day. Telephone interview with Nurse #6 on 2/3/2022 at 2:59 PM revealed he was consistently assigned to care for Resident #31. Nurse #6 stated he was not aware Resident #31 wore antiembolism stockings. Nurse #6 stated he had signed for application of the stockings in error. Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected Nurses to verify completion of treatments prior to signing the TAR.	F 842	HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED The Administrative Nurse will record the results of these audits on a Quality Assurance form and will present the form to the Quality Assurance Committee for review. The Administrative Nurse will also present the Quality Assurance form to the QAPI Committee for review to ensure that the solutions are achieved and sustained. Date of Compliance is 03/11/2022.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 880	Continued From page 60	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD** **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 880

Continued From page 61

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 reviews, and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 5 of 10 staff members (Nurse Aide (NA) #6, NA #1, NA #4, NA #2 and NA #5) working on the 100-hall failed to wear eye protective gear while providing care to residents. These failures occurred during a COVID-19 pandemic.

The findings included:

A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 01/28/22 indicated that the county where the facility was located had a high level of community transmission for COVID-19.

The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 9/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP

F 880

" F-880:
CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

The facility QAPI Committee conducted a Root Cause Analysis of the deficient practice to determine what corrective action needed to be taken.

The Director of Nursing will conduct in-services with all facility nursing staff on wearing of proper eyewear and how to correctly wear eyewear. These in-services will begin on 3-7-2022 and will continue through 3-11-2022.

The Director of Nursing will also email all agencies the facility contracts with for temporary staffing and request that all nursing staff scheduled for Alexandria Place be in-serviced on
wearing of proper eyewear and how to correctly wear eyewear. The Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD GASTONIA, NC 28054

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F 880 Continued From page 62

(Healthcare Personnel):

*If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

A review of the facility policy entitled, "COVID-19 Personal Protective Equipment - Eyewear," revised December 2021 indicated:

2. When the county transmission rate is substantial to high protective eyewear must be worn in all areas and all situations where the employee could have an encounter with a resident (i.e. providing direct resident care, walking down the hallway, in dining rooms, etc.), regardless of whether the facility has any actual positive cases.
3. Approved Personal Protective eyewear for this facility includes: facility approved goggles and face shields. An individual's personal glasses or sunglasses are not considered protective eyewear and are not permitted to be used is lieu of facility provided protective eyewear.

During a continuous observation of the 100-hall on 02/02/22 from 9:35 AM to 10:01 AM there were six (6) NAs in the hall. Five (5) of the 7 NAs were not wearing eye protection on their eyes. NA #4 was wearing her goggles on top of her head and was seen going in and out of resident rooms and assisting residents and other NAs with

F 880

Nursing will send each staffing agency a copy of the in-service materials and will ask that the agencies return signed attendance sheets via email.

HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:

The facility QAPI Committee conducted a Root Cause Analysis of the deficient practice to determine what corrective action needed to be taken and determined that all residents have the potential to be affected by this practice.

The Director of Nursing will conduct in-services with all facility nursing staff on wearing of proper eyewear and how to correctly wear eyewear. These in-services will begin on 3-7-2022 and will continue through 3-11-2022.

The Director of Nursing will also email all agencies the facility contracts with for temporary staffing and request that all nursing staff scheduled for Alexandria Place be in-serviced on wearing of proper eyewear and how to correctly wear eyewear. The Director of Nursing will send each staffing agency a copy of the in-service materials and will ask that the agencies return signed attendance sheets via email.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 880	Continued From page 63 resident care. NA #1 was observed providing care in a room with 2 residents and was noted to be assisting a resident with his blanket and spread on his bed with her goggles up on her head and not on her eyes. NA #5 was stopping to assist residents in the hallway and assisted a resident down the hallway into the shower and provided her assistance with her shower while wearing her goggles on top of her head. NA #5 was observed some time later coming out of the shower room with the resident with her goggles still positioned on top of her head. NA #6 was going in and out of rooms assisting residents and was in the hallway charting with her regular glasses on and no goggles or face shield. NA #2 was interacting with residents and other staff in the hallway and going in and out of rooms assisting with resident care with no goggles or face shield. NA #2 was not wearing glasses or any eye protection while providing resident care and charting out in the hallway. An interview on 02/02/2022 at 10:02 AM with NA #6 revealed it was her second day at the facility providing care to the residents. NA #6 stated she had not been told by anyone at the facility she needed to wear goggles or a face shield while caring for the residents. An interview on 02/02/22 at 11:25 AM with NA #1 revealed she worked for an agency and had worked at the facility for a while. NA #1 stated she had received orientation and it included proper use of personal protective equipment (PPE), and social distancing. She stated she sometimes pushed her goggles up on her head and forgot to put them back on but stated she knew she was supposed to have them on at all times while providing care and in the resident	F 880	MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR: The Director of Nursing, The Infection Control Preventionist and the Administrator will begin observations of staff on each shift (7a-7p and 7p-7a)beginning 03-07-2022 for wearing of protective eyewear and properly wearing the protective eyewear until compliance is achieved. The results of these audits will be recorded on a Quality Assurance Form and will be presented to the Quality Assurance Committee for review. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED The Director of Nursing, The Infection Control Preventionist and the Administrator will present the results of their audits to the Quality Assurance Committee for review. The results of the audits will also be presented to the QAPI Committee for review to ensure that the solutions are achieved and sustained. Compliance date is 03/11/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 880	Continued From page 64	F 880		

hallways when residents were in the hallway as they were today.

An interview on 02/02/22 at 11:45 AM with NA #4 revealed she worked for an agency and had worked at the facility on an as needed basis for several months. NA #4 stated when she first came to the facility, they provided her an orientation to the facility and gave her information on the residents she would be taking care of on a regular basis. NA #4 further stated she knew she was supposed to wear goggles and a face mask at all times while in the resident care areas but had pushed her goggles up on top of her head because they were fogged up and said she just forgot to pull them back down over her eyes.

An interview on 02/02/22 at 12:08 PM with NA #2 revealed she worked for an agency but had been at the facility for several months. NA #4 stated when she came to the facility, she had received orientation which included PPE and the proper use and wear of PPE. NA #4 further stated she usually had her goggles on and had not realized she didn ' t have them on so when she did realize she got a face shield and put it on. She stated she had provided resident care that morning for several hours before putting on a face shield.

An interview on 02/02/22 at 12:36 PM with NA #5 revealed she had worked at the facility for several years. She stated they received frequent in-services on infection control and the proper use of PPE. She stated she had been giving a resident a shower on the 100 hall and was sweating and had pushed her goggles up on top of her head. She further stated she knew she was supposed to have them on at all times while providing resident care but just forgot to pull them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	1770 OAK HOLLOW ROAD 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 880	Continued From page 65 down off her head and put them on her eyes. She stated she knew she was supposed to wear the goggles over her eyes but had just gotten hot and sweaty and had pushed them up on her head. NA #5 stated she had not realized she had been in the hallway and in the shower with the resident with her goggles on her head the whole time and said she had not worn the goggles while providing the resident her shower. An interview on 02/02/22 at 3:04 PM with the Unit Manager revealed she had not noticed the NAs on the hallway without their goggles on. She stated she was concentrating on what she was doing and had not noticed there were 3 NAs with goggles on top of their head instead of on their face, 1 NA with just glasses on and one NA with no glasses, goggles, or a face shield on. She further stated all the NAs working on the 100 and 200 hallways had been educated they were to wear goggles on their eyes and a mask on their face at all times while in the hallways and while in resident rooms providing care. An interview on 02/03/22 at 9:54 AM with the Infection Preventionist (IP) and the Nurse Consultant (NC) revealed with the current high level of community transmission, all staff had been educated to wear a mask and goggles at all times and especially now with positive cases in the building. The IP stated COVID education was ongoing all the time and they were performing audits to ensure staff were wearing PPE, performing hand hygiene between residents and donning and doffing PPE appropriately. They both indicated the Administrator gave weekly updates to all staff and just yesterday all staff had been educated again regarding wearing PPE (mask and goggles or face shield) at all times	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING ______ B. WING ______	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD 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 880	Continued From page 66	F 880		

while in the building. The IP further indicated she expected all staff to wear their mask and goggles or face shield at all times.

An interview on 02/03/22 at 6:30 PM with the Director of Nursing (DON) revealed it was her expectation while the current community transmission in the county was high it was her expectation that all staff wear their appropriate PPE to include a mask and goggles or face shield while in resident care areas and while providing resident care.

An interview with the Administrator on 02/03/22 at 7:32 PM revealed she had just taken over the building as the Administrator in the middle of December 2021. She stated she quickly found out there were systems that were not in place that needed to be in place. The Administrator further stated they had begun to work on some of the systems when their COVID outbreak occurred and then all their attention had been turned to the outbreak and protecting the staff and residents. The Administrator indicated all staff had been educated about the proper use of PPE and it was unacceptable that the staff had not worn their PPE as directed.