STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/25/2024 through 7/3/2024. The facility was found not in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #UTZX11.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		7/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The EP plan did not include contact information for all facility staff, documented alternate facility agreements, and an emergency food subsistence list. The plan did not contain any policy or procedure regarding the methods for sharing information and medical documentation for residents with other health providers to maintain the continuity of care and policies and procedures for tracking staff and residents during an emergency. The findings included: A review of the facility's supplied Emergency Preparedness (EP) plan revealed the Administrator had reviewed the material in January 2024. The following areas were not present, updated, or revised: A. The facility's staff contact information did not contain the names or contact information of the	E 001	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. EOO1 Establishment of the Emergency Program Corrective Action for Affected Residents Beginning 7/8/2024, the Administrator assembled the Emergency Preparedness Plan (EP) to include: an update EP plan, conducted a facility and community based risk assessment, addressing patient/client population, update for current contacts, collaboration with local stakeholders, developed, updated, and reviewed EP policies and procedures regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 001	Continued From page 2 Medical Director (MD) or the Nurse Practitioners (NP). B. The facility's EP plan did not have documented alternate facility agreements. C. The facility's EP plan did not contain an emergency food subsistence list. D. The facility's EP plan did not contain policies and procedures regarding methods for sharing resident information and medical documentation with other health providers/facilities to maintain the continuity of care. E. The facility's EP plan did not contain a system to track the location of on-duty staff and sheltered residents during an emergency. An interview was conducted on 6/27/2024 at 6:47 pm with the Administrator. The Administrator reported she had created the EP plan in January when she started as the Administrator of the facility. The Administrator verified there was no contact information for the MD and NPs in the EP plan and stated that must have been overlooked. The Administrator verified the EP plan did not have any documented alternate facility agreements, however the facility had multiple, but she forgot to place copies of the agreements in the EP book. The Administrator verified the EP plan did not contain an emergency food subsistence list and verbalized she was not aware how much food would be needed to feed all the residents, staff, and volunteers in the event of an emergency. The Administrator verified there was no policies and procedures in place for sharing resident information and medical documentation with other health care	E 001	methods for sharing resident information and medical documentation with other health providers/facilities to maintain continuity of care, addressed subsistence needs for residents and staff, addressed evacuation, transportation, needs of evacuees, and staff responsibilities, updated and reviewed for arrangements with other facilities, reviewed and updated the communication plan, updated names and contact information, and system to track location of on-duty staff and sheltering residents during an emergency. This was completed on 7/15/2024 Corrective Action for Potentially Affected Residents Beginning 7/8/2024, the Administrator assembled the Emergency Preparedness Plan (EP) to include: an updated EP plan, conducted a facility and community based risk assessment, addressing patient/client population, update for current contacts to include Medical Director and Nurse Practitioner, collaboration with local stakeholders, developed, updated, and reviewed EP policies and procedures regarding methods for sharing resident information and medical documentation with other health providers/facilities to maintain continuity of care, addressed subsistence needs for residents and staff, addressed evacuation, transportation, needs of evacuees, and staff responsibilities, updated and reviewed for arrangements with other facilities, reviewed and updated the communication plan, updated names and contact information, and system to track location of on-duty staff and sheltering residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 001	Continued From page 3 providers/facilities in the event of an emergency and reported the facility had hired a new Health Information Manager that was in the process of working on creating policies and procedures for information sharing. The Administrator verified the EP plan did not contain a system to track staff, residents, and volunteers sheltering in place in the event of an emergency. The Administrator stated there were policies for tracking staff and residents, however she had forgotten to place tracking logs and the tracking procedures in the EP book.	E 001	during an emergency. This was completed on 7/15/2024 Systemic Changes The Administrator was in serviced on 7/9/2024 by the Regional Quality Assurance Nurse regarding the importance of developing and maintaining the EP plan within the facility including but not limited to: an update EP plan, conducted a facility and community based risk assessment, addressing patient/client population, update for current contacts, collaboration with local stakeholders, developed, updated, and reviewed EP policies and procedures regarding methods for sharing resident information and medical documentation with other health providers/facilities to maintain continuity of care, addressed subsistence needs for residents and staff, addressed evacuation, transportation, needs of evacuees, and staff responsibilities, updated and reviewed for arrangements with other facilities, reviewed and updated the communication plan, updated names and contact information, and system to track location of on-duty staff and sheltering residents during an emergency. This training will be included in new hire orientation for any newly hired Administrator. Quality Assurance Beginning the week of 7/22/2024, The Regional Director of Operations or Regional Quality Assurance Nurse will review the EP Plan, via in person or electronically, weekly for 4 weeks and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 001	Continued From page 4	E 001	monthly for 2 months to ensure the plan is updated and intact. The EP Plan review will be brought to the Facility QA team meetings for review by the QA team. Any incidents of non-compliance will result in continued reviews. Date of Compliance: 7/16/2024	
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 6/25/2024 through 6/28/2024. The credible allegation of IJ removal was validated on 7/3/2024. Therefore, the exit date was changed to 7/3/2024. The following intakes were investigated NC00213052, NC00213259, NC00217279, NC00214184, NC00213200, NC00211290 and NC00213867. 8 of the 15 complaint allegation(s) resulted in deficiency. Intake NC00213867 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J CFR 483.12 at tag F600 at a scope and severity of J CFR 483.25 at tag F684 at a scope and severity of J The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 2/2/2024 and was removed on 6/29/2024. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 550	Continued From page 5 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 550	Continued From page 6 subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to treat a resident with dignity and respect when a nurse aide was witnessed with her hand raised to a cognitively impaired resident's face during an interaction in the resident's room for 1 of 4 residents reviewed for dignity (Resident #41). A reasonable person would not like someone raising a hand in front of their face. The findings included: Resident #41 was admitted to the facility on 04/08/21. Review of Resident #41's quarterly Minimum Data Set assessment dated 11/23/23 revealed Resident #41 was moderately cognitively impaired. Review of facility provided allegations of abuse, neglect, or misappropriation revealed Resident #41 was involved in an altercation with Nurse Aide #10 on 01/27/24 in which Nurse Aide #11 heard shouting coming from Resident #41's room and when she arrived, she witnessed Nurse Aide #10 and Resident #41 standing close together and face to face with Nurse Aide #10's hand raised in the air toward Resident #41's face. An interview with Nurse Aide #11 on 06/27/24 at 2;56 PM revealed she was working the evening of 01/27/24 and late in the evening, she heard shouting coming from Resident #41's room. Nurse Aide #11 reported she went to the room and when she walked into the room, she	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 Resident Rights/Exercise of Rights Corrective Action for Affected Residents For resident # 41, a corrective action was obtained on 1/27/2024. NA#11 provided care for resident #41. On 1/28/2024, NA#10 was suspended pending investigation. Initial allegation report submitted the State Reporting Agency. Corrective Action for Potentially Affected Residents All residents who need assistance with activities of daily living have the potential to be affected by this alleged deficient practice. Beginning 7/8/2024, the Director of Nursing and Nurse Managers performed body audits for residents with BIMS 12 or less and completed interviews with residents with BIMS 13 or higher to identify any concerns related to care/dignity and respect. The results of identified no other resident affected by alleged deficient practice. This was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 550	Continued From page 7 observed Nurse Aide #10 and Resident #41 standing face to face and Nurse Aide #10 had her right arm raised and indicated by the time she got to the room no one was shouting. She stated the way Nurse Aide #10's arm was raised she felt that Nurse Aide #10 was possibly going to put her hand over Resident #41's mouth or potentially strike her. Nurse Aide #11 reported she did not observe Nurse Aide #10 strike Resident #41 or cover her mouth but did ask Nurse Aide if she needed her to take over, to which Nurse Aide #10 replied "no" and then left the room. Nurse Aide #11 stated she stayed with Resident #41 who did not appear to be upset and then went and told her hall nurse what she had observed, though she could not recall her name. Nurse Aide #11 stated she also could not recall if Nurse Aide #10 worked the rest of her shift or not. An interview with Resident #41 was completed on 06/27/24 at 4:47 PM. Resident #41 had no recollection of the event and stated she felt safe at the facility. Resident #41 did not report any issues or concerns at that time. Review of facility provided schedules revealed Nurse #8 was assigned as the hall nurse the night of the incident. Multiple attempts to reach Nurse #8 by telephone were unsuccessful. Multiple attempts to reach Nurse Aide #10 by telephone were unsuccessful. Additional review of the facility's investigation into the incident revealed Nurse Aide #10 did not provide a written statement regarding the incident.	F 550	completed on 7/10/2024. Additionally, on 7/12/2024, the Administrator reviewed grievance logs for the past 30 days to identify concerns related to care/dignity and respect. The audit identified one grievance noted related to care which had been resolved. Systemic Changes On 7/8/2024, the Director of Nursing began in-servicing all current full time, part time and PRN (as needed) staff including agency. This in-service included the following topics: " Resident Rights " Customer Service The Director of Nursing will ensure that any full-time, part-time and PRN (as needed) staff including agency who has not received this training by 7/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The Director of Nuursing will ensure the facility specific in-service will be provided to all agency staff who give residents care in the facility prior to working their shift. Quality Assurance Beginning the week of 7/22/2024, The Director of Nursing or designee will monitor this issue using the Survey	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 550	Continued From page 8 An interview with the Administrator on 06/28/24 at 1:28 PM revealed she was the facility's abuse coordinator and that she remembered the incident and stated it was her understanding that Nurse Aide #11 observed Nurse Aide #10 raise her hand in the face of Resident #41. The Administrator reported Nurse Aide #10 was terminated and followed up by stating she expected her staff to treat all residents in the facility with respect and dignity, even if the resident was being difficult. She indicated Nurse Aide #10 should have removed herself from the situation and returned at a later time if Resident #41 was having a difficult moment instead of becoming confrontational.	F 550	Quality Assurance Tool for Monitoring Residents Rights. The monitoring will include reviewing a sample of 5 residents to ensure staff are treating them with dignity and respect at all times. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved. Reports will be presented by the Director of Nursing to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurses, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager Human Resource Specialist, Maintenance Director and Social Worker. Date of compliance: 7/16/2024	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 578	Continued From page 9 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident's code status election was accurate throughout the medical record for 1 of 4 residents reviewed for advanced directives (Resident # 57). The findings included: Resident #57 was admitted to the facility on 2/28/2024 with a diagnosis of adult failure to thrive.	F 578	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F578 REQUEST/	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 578	Continued From page 10 A quarterly Minimum Data Set (MDS) dated 4/20/2024 revealed Resident #57 was cognitively intact. A review of a care plan dated 6/3/2024 revealed Resident #57 had an unspecified advanced directive in place and his wishes were to be honored. A review of the advanced directives book at the nurse's station conducted on 6/25/2024 at 3:46 pm revealed Resident #57 had a Do Not Resuscitate (DNR) form dated 6/21/2024 and was signed by the MD and a Medical Orders for Scope of Treatment (MOST) form dated 6/21/2024 revealed Resident #57 wanted CPR and full scope of treatment and was signed by the MD. A review of a physician's order dated 6/26/2024 revealed Resident #57 wanted to receive Cardiopulmonary Resuscitation (CPR, chest compressions to restart the heart) with limited interventions. During an interview on 6/26/24 at 2:15 PM Resident #57 stated he wanted to be a full code with a full scope of treatment. An interview was conducted on 6/26/2024 at 2:10 pm with Nurse Supervisor #1. Nurse Supervisor #1 stated when a resident was admitted to the facility, the Nurse on the hall reviewed the DNR and MOST forms with the resident and would complete the form. The completed forms were then given to a Nurse Supervisor, placed in the provider book, signed by the provider, and placed in the advanced directives book at the appropriate nurse's station. The hall	F 578	REFUSE/DISCONTINUE TRMNT; FORMLTE ADV DIR Regarding the alleged deficient practice of failure to clarify code status for resident #57. On 6/26/2024, the Director of Nursing updated resident code status to CPR/Full Scope of Treatment per Medical Orders for Scope of Treatment (MOST) form per the resident□s preferences. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current facility residents have the potential to be affected by the alleged deficient practice of failure to clarify code status. The Health Information Manager (HIM) completed an audit of Advanced Directives for current facility residents on 7/8/2024 to ensure code status current. This was completed on 7/10/2024. The results of the audit identified no other residents affected by alleged deficient practice. Additionally, on 7/8/2024 the HIM Director completed a 100% audit of Advanced Directives for all residents within the facility to validate Do Not Resuscitate form, the MOST form and Physician orders were accurate and resident□s advanced directive form was current and up to date in Advanced Directive Book. This was completed on 7/9/2024. No additional concerns were identified. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/8/2024, the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 578	Continued From page 11 nurse/admission nurse was responsible for entering the appropriate code status order in the Electronic Medical Record (EMR) if known at the time of admission. Nurse Supervisor #1 stated Resident #57 had an order for a full code. Nurse Supervisor #1 stated she was unsure of why there was a MOST form indicating full code with full scope of treatment and a DNR dated the same day. Nurse Supervisor #1 stated the advanced directives should match and reflect the resident's wishes. Nurse Supervisor #1 was not able to identify who completed the forms and stated it must have been overlooked. An interview was conducted on 6/26/2024 at 2:17 pm with the Medical Records Coordinator. The Medical Records Coordinator reported she had just transitioned to that role and had only completed 4 days of orientation. The Medical Records Coordinator stated she had to collect the MOST and DNR forms and scan them into the Electronic Health Record (EHR) and place the documents in the advanced directives book at the appropriate nurse's station. The Medical Records Coordinator stated Resident #57's MOST form should reflect his wishes and a resident should not have a DNR with a MOST form indicating full code with a full scope of treatment. An interview was conducted on 6/26/2024 at 2:18 pm with the Admission Coordinator. The Admission Coordinator stated she enters the resident's code status, if known, into the EHR on admission. The Admission Coordinator reported she did not complete the DNR or MOST form and stated that both forms were in the admissions packet to be completed by the hall/admissions nurse.	F 578	began in servicing education for the licensed nursing staff and social workers regarding completion of Advanced Directives upon admission to include Advanced Directives election form, Physician order and DNR or MOST form. The Licensed Nurses or the Social worker will assist the resident and/or the family to complete the Advanced Directive form upon admission. If the resident wishes are for a Do not resuscitate (DNR) or MOST the Physician will be notified and an order written to support the resident wishes, and the DNR or MOST form will be completed and signed by the physician. The forms will be placed in the resident□s medical record upon completion. The Physicians order will be included in the order section of the resident□s electronic medical record. The Director of Nursing will ensure that any of the above identified full-time, part-time and PRN (as needed) staff who has not received this training by 7/15/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained.The Director of Nursing will ensure the facility specific in-service will be provided to all licensed agency staff who give residents care in the facility prior to working their shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 578	Continued From page 12 An interview was conducted on 6/28/2024 at 11:33 am with the Nurse Practitioner (NP). The NP stated on admission the admissions nurse would go over and complete the MOST and DNR forms with the resident and their family. The NP stated during an initial visit with a resident, she would go over resident's code status information and verify the MOST/DNR forms at that time. The NP stated the MOST form and DNR should reflect the resident's wishes. The NP stated that Resident #57's MOST form should not indicate he was a full code with a full scope of treatment if he wanted to be a DNR and vice versa. The NP said that was an error. The NP stated the admission packets had a DNR and MOST form. The NP stated it was not uncommon for both forms to be left completed on her desk and could have easily been looked over by the provider when signing admission paperwork. An interview was conducted on 6/28/2024 at 11:37 am with the Social Worker (SW). The SW stated she was not responsible for completing the MOST and DNR forms when a resident was admitted. The SW stated if a resident had a Health Care Power of Attorney (HCPOA) or a living will, she would obtain copies on admission. The SW stated Resident #57 wanted to be a full code and should not have had a signed DNR form in the advanced directives book at the nurse's station. An interview was conducted on 6/28/2024 at 12:13 pm with the Interim Director of Nursing (DON). The Interim DON verified the hall/admissions nurse was responsible for completing the MOST and DNR forms according to the resident's wishes. The Interim DON stated she had been made aware of Resident #57	F 578	Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024, The Health Information Manager will audit 5 resident records to ensure that the code status order was obtained and accurate based on the resident preference and placed in resident medical record. This audit will be completed weekly x 4 weeks then monthly x 2 months. Reports will be presented by the Director of Nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurses, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager Human Resource Specialist, Maintenance Director and Social Worker. Date of Compliance: 7/16/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 578	Continued From page 13 having a MOST form indicating full code and full scope of treatment and a signed DNR form. The Interim DON stated that was an error and Resident #57 wished to be a full code.	F 578		
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; (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	F 580		7/4/24

(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 14 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 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to notify a medical provider when Resident #278 was noted by Medication Aide (MA) #1 to have difficulty breathing, had an oxygen saturation in the high 70's/low 80's (normal oxygen saturation is 92 to 100%), and was asking for help. On 2/2/2024 at 7:00 am MA #1 was told by Nurse #2 that Resident #278 was having issues with breathing. MA #1 checked Resident #278 and noted an oxygen saturation in the "high 70's/low 80's," and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor her oxygen saturation levels. MA #1 reported Resident #278's oxygen saturation levels remained in the 80's and she appeared to be struggling to breathe and was asking for help. MA #1 continued to report breathing issues and concern about Resident #278 throughout the shift to the DON	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580- Notification of Change (Injury, Decline, Room. Etc.) Corrective action for affected residents. Resident #278 had a cough and on 01/23/2024, Nurse #1 notified the provider of resident representative request for a chest x- ray. On 01/24/2024, the provider assessed Resident #278 and did not order a chest x-ray. The facility didn□t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 15 until Resident #278 was removed from the facility on 2/2/2024 at 4:47 pm by Resident #278's Representative (RR). The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on 2/8/2024, received inpatient hospice services in the hospital and expired on 2/12/2024. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents reviewed for notification of change in condition (Resident #278). Immediate jeopardy began on 2/2/2024 when Resident #278's was noted to have an oxygen saturation level in the "high 70's/low 80's" by MA #1 and the physician was not notified. Immediate jeopardy was removed on 6/29/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #278 was re-admitted to the facility on 11/1/2023 with a diagnosis of heart disease.	F 580	perform a chest x-ray requested by Resident #278□s Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider did order Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on 02/02/2024. Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on 02/02/2024 to an Acute Care Hospital by the resident representative. The facility failed to notify a provider when Resident #278 was noted by Medication Aide #1 to have difficulty breathing, had an oxygen saturation of the high 70□s/low 80□s, and was asking for help. Corrective action for potentially affected residents. All residents are at risk of harm or due to the deficient practice. On 06/28/2024, the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to ensure the provider was notified of the change in condition. The change in condition included: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY** **BLOWING ROCK, NC 28605**

(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 16 A review of a Medical Orders for Scope of Treatment (MOST) form dated 9/30/2022 revealed Resident #278 was a full code and wished to receive all medical interventions including intubation, advanced airway interventions, mechanical ventilation, cardioversion (a procedure using electricity and medications to convert the heart from an irregular to a regular rhythm) as indicated, medical treatment, intravenous fluids, and to be transferred to the hospital if indicated. A review of a care plan dated 11/3/2024 revealed Resident #278 had an advanced directive in place and her wishes were to be honored. A telephone interview was conducted on 6/27/2024 at 7:30 pm with MA #1. MA #1 reported she worked on 2/2/2024 during dayshift (7:00 am to 7:00 pm) and was assigned Resident #278. MA #1 stated she received a report from Nurse #2 at 7:00 am and was told by Nurse #2 that Resident #278 was not doing well. MA #1 reported she immediately checked on Resident #278 at 7:00 am and noticed Resident #278 was "struggling with breathing and asking for help." MA #1 reported she obtained an oxygen saturation level in the "low 70's/high 80's" but was unable to recall the exact result. MA #1 stated she immediately got the DON and was instructed to place Resident #278 on oxygen and to continue checking oxygen saturation levels. MA #1 was not able to recall the DON performing an assessment. MA #1 reported she placed Resident #278 on oxygen; however, she was unable to recall the exact liters/minute and routinely checked Resident #278's oxygen level throughout the shift. MA #1 reported she had not	F 580	prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, and new onset cough, congestion with decreased appetite. This audit was completed on: 06/28/2024. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. On 06/28/2024, a corrective action was completed for 2 of 79 residents identified as having a change in condition when the provider was notified of the change in condition and orders for the change in condition were carried out by the direct care staff. On 06/28/2024, the Administrator audited all residents transferred to the hospital in the last 30 days (05/28/2024 - 06/28/2024) to ensure provider notification was completed for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 17	F 580		

recalled Resident #278's oxygen level rising above 90%. MA #1 stated she repeatedly told the DON about Resident #278 struggling to breathe, low oxygen saturation levels, and how she felt Resident #278 "needed to be sent to the hospital" throughout the shift, but "no one would listen to her." MA #1 reported she had not called the provider, because she had communicated concerns to the DON. MA #1 stated she continued to check Resident #278's oxygen saturation often but was unable to recall getting a full set of vital signs.

A review of the February 2024 Medication Administration Record (MAR) revealed no documented vital signs.

An attempt was made to contact Nurse #2 on 6/27/2024 and was unsuccessful.

The DON was unavailable for an interview.

A review of a progress note dated 2/2/2024 at 4:47 pm written by the Social Worker (SW), revealed Resident #278 RR came to the facility on 2/2/2024 and the Resident Representative (RR) removed Resident #278 from the facility. The SW asked the RR to take an oxygen tank with them due to Resident #278's oxygen levels had been falling at times, but they refused and stated they were going straight to the Emergency Room from the facility and declined the offer.

An interview was conducted on 6/27/2024 at 2:10 pm with the SW. The SW reported on 2/2/2024 a conversation was had between the Administrator and the RR, and the RR arrived at the facility upset and removed Resident #278 from the facility. The SW reported that when the RR

audit identified that provider notification was completed for 22 of 22 residents. No current residents were identified as not having provider notification, therefore no corrective action was required.
Systemic changes
On 06/28/2024 the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on the need to notify the provider for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite.
The DON will ensure that all licensed nurses, RN□s, LPN□s, and CNA□s (full time, part time, and prn including agency) who do not complete the in-service training by 06/28/2024 will not be allowed to work until the training is completed.
This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency) by the Director of Nursing.
Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 18 arrived, she went to the room with her to pack up Resident #278's belongings. The RR stated Resident #278 was "really sick" and they were going to take her straight to the Emergency Department. The SW stated Resident #278 had been having respiratory issues and had received treatment for respiratory symptoms. The SW recalled MA #1 was in the process of calling the on-call medical provider when the RR arrived due to concern over Resident #278's breathing and was concerned that the respiratory issues had progressed to pneumonia. The SW stated she informed the RR that MA #1 was calling the MD, but the RR insisted on removing Resident #278 from the facility anyway. The SW stated she offered the RR an emergency oxygen tank to take with them for their drive to the hospital and the RR refused. A follow-up interview was conducted on 6/28/2024 at 11:41 am with the SW. The SW reported she had walked down 400 hall and remembered MA #1 stating Resident #278 "was not doing very good and did not look good" around lunch time, 11:30 am. The SW stated she asked MA #1 if she had notified anyone. The SW stated she went in the room at 11:30 am and observed Resident #278 on oxygen and stated she looked sick. The SW stated after she left the room, she immediately went to get the DON and was met near the front entrance of the facility by the RR. An interview was conducted on 6/27/2024 at 3:57 pm with Nurse Supervisor #1. Nurse Supervisor #1stated she worked on 2/2/2024. Nurse Supervisor #1 reported she had not gone to assess Resident #278 because she was never informed by MA #1 that Resident #278 was	F 580	requirements. Beginning the week of 7/8/2024, the Administrator or designee will audit this process using the Quality Assurance Tool for Monitoring Compliance with the notification of change in condition and EMS if needed. This audit will be completed weekly x 4 weeks, then monthly x 2 months or until resolved. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager and Dietary Manager. Date of Compliance: 7/4/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 19	F 580		

having difficulty breathing. Nurse Supervisor #1 stated she had not notified the NP because she was not aware Resident #278 had low oxygen saturation levels or difficulty breathing at that time.

An interview was conducted on 6/27/2024 at 4:40 pm with Nurse Supervisor #2. Nurse Supervisor #2 reported she had worked with Resident #278 a few times and remembered that she had been lying in bed more often and she had a cough. She stated Resident #278 was tested for Influenza and COVID at the facility, however she was not able to locate the Influenza results. Nurse Supervisor #2 stated if Resident #278 had been having upper respiratory infection symptoms, nursing assessment should have been completed. Nurse Supervisor #2 reported if Resident #278 had a change in condition, low oxygen saturation levels, or respiratory distress a provider should have been notified.

An interview was conducted on 6/28/2024 at 11:12 am with the NP. The NP reported she had seen Resident #278 on 1/24/2024 at which time Resident #278 had a cough and congestion. The NP stated she never received any additional notification that Resident #278 had continued to have respiratory issues.

A telephone interview was conducted on 6/27/2024 at 4:16 pm with the MD. The MD stated he was not aware that Resident #278 had been taken to the Emergency Department on 2/2/2024 after the RR removed her from the facility where she subsequently expired. The MD reported he had not been made aware of any respiratory issues or low oxygen saturation levels and that a medical provider should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 20	F 580		

notified because Resident #278 may have needed to be transferred to the hospital.

An interview was conducted on 6/27/2024 at 2:35 pm with the Administrator. The Administrator reported she was not aware Resident #278 had a low oxygen saturation of the high 70's/low 80's and a medical provider had not been notified.

A review of the Emergency Department records dated 2/2/2024 revealed Resident #278 presented to the hospital for evaluation of cough, congestion, and shortness of breath and had no respiratory history of Chronic Obstructive Pulmonary Disease (COPD, an inflammatory lung disease which causes difficulty breathing) or chronic respiratory illnesses. The RR stated Resident #278 had a cough and congestion for 2 weeks and they had asked for Resident #278 to be evaluated at the facility and felt like "she had been neglected." Resident #278 reported weakness, cough, congestion, sore throat, and pleuritic pain (chest pain that gets worse with breathing). Resident #278 had an elevated white blood cell count (which indicated infection) of 14.4, a blood urea nitrogen (BUN) level of 24 (indicating mild dehydration), tested positive for Influenza A and received Decadron (a steroid used to reduce inflammation), intravenous fluid bolus (to improve dehydration), and a Duo-neb (a breathing treatment given through a nebulizer) treatment. Resident #278 was admitted to the hospital with a diagnosis of Influenza A and Influenzal Bronchitis.

A review of the Acute Hospital Death Summary dated 2/12/2024 at 5:55 pm revealed Resident #278 had presented to the hospital on 2/2/2024 with acute hypoxemic respiratory failure, tested

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 21	F 580		

positive for Influenza A and had a superimposed bacterial infection with Methicillin-resistant Staphylococcus aureus (MRSA, an infection resistant to many antibiotics) positivity. Resident #278 had right lower lobe consolidation (which indicates pneumonia), had received Vancomycin (antibiotic used to treat a wide variety of infections) and Rocephin (antibiotic used to treat respiratory tract infections). Resident #278 had increased oxygen requirements throughout her hospitalization and the infection continued to progress causing mucous plugging (mucous that builds up in the lungs and reduces the flow of air). Due to Resident #278's weak cough and debility, the RR placed Resident #278 on comfort measures and Resident #278 received inpatient hospice services in the hospital and died on 2/12/2024 at 5:55 pm with the RR at bedside.

A review of a Certificate of Death dated 2/20/2024 revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia.

The Administrator was made aware of Immediate Jeopardy on 6/28/2024 at 9:48 am.

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

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

Resident #278 had a cough and on 01/23/2024, Nurse #1 notified the provider of resident representative request for a chest x- ray. On 01/24/2024, the provider assessed Resident #278 and did not order a chest x-ray. The facility didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 22	F 580		

perform a chest x-ray requested by Resident #278's Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider ordered Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on 02/02/2024. The Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on 02/02/2024 to an Acute Care Hospital by the resident representative. The facility failed to notify a provider when Resident #278 was noted by Medication Aide #1 to have difficulty breathing, had an oxygen saturation of the high 70's/low 80's, and was asking for help.

All residents are at risk of harm or due to the deficient practice. On 06/28/2024, the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to ensure the provider was notified of the change in condition. The change in condition included: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, and new onset cough, congestion with decreased appetite. This audit was completed on: 06/28/2024. The audit identified that 2 of 79 residents had an acute change in condition to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 23

include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. On 06/28/2024, corrective action was completed for 2 of 79 residents identified as having a change in condition when the provider was notified of the change in condition and orders for the change in condition were carried out by the direct care staff.

On 06/28/2024, the Administrator audited all residents transferred to the hospital in the last 30 days (05/28/2024 - 06/28/2024) to ensure provider notification was completed for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. The audit identified that provider notification was completed for 22 of 22 residents. No current residents were identified as not having provider notification; therefore, no corrective action was required.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed:

On 06/28/2024 the Director of Nursing began in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 24	F 580		

servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on the need to notify the provider for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite.

The DON will ensure that all licensed nurses, RNs, LPNs, and CNAs (full time, part time, and prn including agency) who do not complete the in-service training by 06/28/2024 will not be allowed to work until the training is completed.

This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency) by the Director of Nursing.

Alleged date of IJ removal 06/29/2024

A validation of immediate jeopardy removal was conducted on 7/3/2024. The initial audit of residents was reviewed, and no issues were noted. Staff interviews across all departments were able to verbalize that they had received education on notification of change it condition, examples of change in condition, who to notify of a change in resident condition, etc. The staff were able to verbalize examples of a change in condition and the appropriate steps to take in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 25 notification, including the hall nurse, Director of Nursing, Administrator, and medical provider. The immediate jeopardy removal date of 6/29/2024 was validated.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, and Resident Representative (RR), staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to protect a Resident's right to be free from neglect when they failed to provide effective care and services to a resident experiencing a medical emergency. On 2/2/2024 MA #1 was told by Nurse #2 that Resident #278 was not doing well. MA #1 checked Resident #278 and noted an oxygen saturation in the "high 70's/low 80's" (normal oxygen saturation is 92 to 100%), and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and monitor oxygen saturation levels.	F 600	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F600 Free from Abuse and Neglect Corrective action for affected residents.	7/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 26 MA #1 continued to report breathing issues and concern about Resident #278 to the DON throughout the day until Resident #278 was removed from the facility by the RR at 4:47 pm. The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on 2/8/2024, received inpatient hospice services in the hospital and expired on 2/12/2024. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 4 residents (Resident #278) reviewed for neglect. Immediate jeopardy began on 2/2/2024 when Resident #278 experienced an acute change in condition and the facility neglected to provide effective care and services during a medical emergency. Immediate jeopardy was removed on 6/29/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included:	F 600	On 2/2/2024, Facility failed to follow abuse/neglect policy related to prohibiting neglect when Resident #278 had a change of condition and facility staff failed to notify Medical Director or Nurse Practitioner of change in condition and failed to notify Emergency Medical Services. Resident #278 had a cough and on 01/23/2024, Nurse #1 notified the provider of resident representative request for a chest x- ray. On 01/24/2024, the provider assessed Resident #278 and did not order a chest x-ray. The facility didn□t perform a chest x-ray requested by Resident #278□s Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider did order Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on 02/02/2024. Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on 02/02/2024 to an Acute Care Hospital by the resident representative. The facility failed to notify a provider when Resident #278 was noted by Medication Aide #1 to have difficulty breathing, had an oxygen saturation of the high 70□s/low 80□s, and was asking for help. On 6/28/2024, Upon being made aware of allegation of neglect, Administrator completed and submitted initial allegation report to Department of	

F 600

Continued From page 27

This tag is cross-referenced to:

F684: Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to complete and document on-going thorough assessments for an acute change in condition and failed to respond effectively to a medical emergency. On 1/23/2024 at 7:00 pm, Resident #278's Representative requested a chest x-ray, when Nurse #1 observed Resident #278 had a cough, congestion, and decreased appetite. Resident #278 was seen by the NP on 1/24/2024 who ordered an oral medication for breaking up mucous/congestion every 12 hours and nebulizer breathing treatments four times a day were ordered for 7 days for a cough. On 2/2/2024 at 7:00 am, Medication Aide (MA) #1 was told by the off going nurse, Nurse #2, that Resident #278 was not doing well. MA #1 checked Resident #278's oxygen saturation and noted it was in the "high 70's/low 80's" (normal oxygen saturation is 92 to 100%) and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor oxygen saturation levels. MA #1 continued to report breathing issues and concern about Resident #278 struggling to breathe to the DON throughout the day until Resident #278 was removed from the facility by the RR at 4:47 pm. The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection),

F 600

Health and Human Services. On 6/28/2024, all current residents were assessed for change in condition to ensure anyone requiring change in condition received necessary care & services.
Corrective action for potentially affected residents.
On 6/28/2024, the Director of Nursing identified residents that were potentially impacted by this practice by completing head to toe body audits and assessed residents for any acute distress or verbal/nonverbal indicators of neglect with a BIMS 12 or less on all current residents. The results included: all current residents with BIMS 12 (impaired cognition) or less had no areas of concern identified related to abuse/neglect. On 6/28/2024, all current residents with a BIMS of 13 or above were interviewed by the Administrator and were asked if they had any concerns related to abuse/neglect and if they had any care concerns. The results included: All current resident with BIMS 13 (intact cognition) or higher denied any allegations of abuse/neglect occurred and identified.
Additionally, on 06/28/2024, the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to ensure the provider was notified of the change in condition. The change in condition included: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 28 and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on 2/8/2024, received inpatient hospice services in the hospital and expired on 2/12/2024. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents (Resident #278) reviewed for change in condition. F580: Based on record review, staff, Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to notify a medical provider when Resident #278 was noted by Medication Aide (MA) #1 to have difficulty breathing, had an oxygen saturation in the high 70's/low 80's (normal oxygen saturation is 92 to 100%), and was asking for help. On 2/2/2024 at 7:00 am MA #1 was told by Nurse #2 that Resident #278 was having issues with breathing. MA #1 checked Resident #278 and noted an oxygen saturation in the "high 70's/low 80's," and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor her oxygen saturation levels. MA #1 reported Resident #278's oxygen saturation levels remained in the 80's and she appeared to be struggling to breathe and was asking for help. MA #1 continued to report breathing issues and concern about Resident #278 throughout the shift to the DON until Resident #278 was removed from the facility on 2/2/2024 at 4:47 pm by Resident #278's Representative (RR). The RR took Resident #278 to the Emergency Department where	F 600	marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, and new onset cough, congestion with decreased appetite. This audit was completed on: 06/28/2024. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. On 06/28/2024, a corrective action was completed for 2 of 79 residents identified as having a change in condition when the provider was notified of the change in condition and orders for the change in condition were carried out by the direct care staff On 06/28/2024, the Administrator audited all residents transferred to the hospital in the last 30 days (05/28/2024 - 06/28/2024) to ensure provider notification was completed for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 29 Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on 2/8/2024, received inpatient hospice services in the hospital and expired on 2/12/2024. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents reviewed for notification of change in condition (Resident #278). An interview was conducted on 6/27/2024 at 7:30 pm with Medication Aide (MA) #1. MA #1 stated she had received education on abuse and neglect from the facility. MA #1 stated an example of neglect would be not sending a resident to the hospital with a low oxygen saturation level that had not improved. MA #1 stated she felt as though Resident #278 had been neglected because the DON had not allowed her to send Resident #278 to the hospital. An interview was conducted on 6/28/2024 at 11:41 am with the Social Worker (SW). The SW stated staff used an online learning center to receive training. The SW reported staff continuously had training on neglect and abuse through their online learning center, in-services, monthly meetings, and on an as needed basis. The SW stated if a resident had a change in condition, such as a low oxygen saturation and difficulty breathing, and had not notified a medical	F 600	resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. The audit identified that provider notification was completed for 22 of 22 residents. No current residents were identified as not having provider notification, therefore no corrective action was required. Systemic changes On 6/28/2024, Administrator and the Director of Nursing (DON) conducted in service for all full-time, part-time and as needed staff including agency on the abuse/neglect policy for reporting, identifying, and preventing abuse and neglect. All staff (full-time, part-time, and PRN staff, administration, housekeeping, dietary, nursing, therapy and maintenance) were in-serviced on identifying/reporting abuse/neglect immediately using our abuse policy and procedure. This education was completed in person and by phone. Any staff that was not educated by 6/28/24 will not be allowed to work until education is completed by Administration or department heads. Additionally, on 06/28/2024 the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), Medication Aides and certified nursing assistants (full time, part time, and prn including agency) on the need to notify the provider for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600

Continued From page 30

provider, that could be considered neglect.

An interview was conducted on 6/28/2024 at 12:39 pm with the Interim Director of Nursing (DON). The Interim DON stated facility staff received training on abuse and neglect yearly and as needed if an issue arose. The Interim DON stated neglect would be classified as "not taking care of a resident and not acknowledging or reporting an issue with a resident." The Interim DON stated MA #1 not reporting a change in condition and not having a nurse come assess Resident #278 could be classified as neglect.

An interview was conducted on 6/28/2024 at 11:56 am with the Administrator. The Administrator stated the facility utilized an online learning center for education and staff were educated on abuse and neglect during orientation. The Administrator stated neglect would be "a resident who has not been bathed or changed." The Administrator stated she would not consider, not notifying a medical provider about a change in condition and not performing an assessment for a resident with a change in condition, to be neglect but instead a "miscommunication."

The Administrator was made aware of Immediate Jeopardy on 6/28/2024 at 10:49 am.

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

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

On 2/2/2024, Facility failed to follow

F 600

unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. This education included: types of change in conditions, what to do when a change in condition is noted, who to notify, initiating Emergency Medical Services if needed and importance of providing care and services for any change in condition promptly and if care or services are not provided including not initiating call for Emergency Medical Services for assistance during a medical emergency is neglect.
The Interdisciplinary Team (Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Pharmacist), were notified of the allegation of neglect related to facilities failure in following and implementing policy related to abuse/neglect, identifying neglect and addressing change of condition in resident on 06/28/2024 and were involved in the removal plan.
The Administrator and Director of Nurses will ensure that any staff member (full time, part time, and prn including agency) who do not complete the in-service training by 06/28/2024 will not be allowed to work until the training is completed.
This in-service was incorporated into the new employee facility and agency orientation for all staff (full time, part time, and prn including agency) by the Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 31 abuse/neglect policy related to prohibiting neglect when Resident #278 had a change of condition and facility staff failed to notify Medical Director or Nurse Practitioner of change in condition and failed to notify Emergency Medical Services. Resident #278 had a cough and on 01/23/2024, Nurse #1 notified the provider of resident representative request for a chest x- ray. On 01/24/2024, the provider assessed Resident #278 and did not order a chest x-ray. The facility didn't perform a chest x-ray requested by Resident #278's Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider did order Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on 02/02/2024. Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on 02/02/2024 to an Acute Care Hospital by the resident representative. The facility failed to notify a provider when Resident #278 was noted by Medication Aide #1 to have difficulty breathing, had an oxygen saturation of the high 70's/low 80's, and was asking for help. On 6/28/2024, Upon being made aware of allegation of neglect, Administrator completed and submitted initial allegation report to Department of Health and Human Services. On 6/28/2024, all current residents were assessed for change in condition to ensure anyone requiring change in condition received necessary care & services. On 6/28/2024, the Director of Nursing identified residents that were potentially impacted by this	F 600	of Nurses. Quality Assurance Beginning the week of 7/8/2024, The Administrator or designee will monitor the abuse/neglect process to ensure residents are free from neglect and any neglect identified reported and addressed according to facility policy using the QA Tool for Recognizing and Reporting Abuse/Neglect. The Administrator or designee will interview 5 staff members to monitor if staff know the procedure for reporting alleged abuse/neglect and when and who to report to and 5 residents related to abuse/neglect concerns. Also, the Administrator or designee will review allegation reports submitted to State Survey Agencies to ensure reports submitted per facility policy. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Support nurse, Therapy Director Social Worker, Maintenance Director, Health Information Management and Dietary Manager. Date of Compliance: 7/4/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY** **BLOWING ROCK, NC 28605**

(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 600	Continued From page 32 practice by completing head to toe body audits and assessed residents for any acute distress or verbal/nonverbal indicators of neglect with a BIMS 12 or less on all current residents. The results included: all current residents with BIMS 12 (impaired cognition) or less had no areas of concern identified related to abuse/neglect. On 6/28/2024, all current residents with a BIMS of 13 or above were interviewed by the Administrator and were asked if they had any concerns related to abuse/neglect and if they had any care concerns. The results included: All current resident with BIMS 13 (intact cognition) or higher denied any allegations of abuse/neglect occurred and identified. Additionally, on 06/28/2024, the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to ensure the provider was notified of the change in condition. The change in condition included: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, and new onset cough, congestion with decreased appetite. This audit was completed on: 06/28/2024. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 33	F 600		

change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. On 06/28/2024, a corrective action was completed for 2 of 79 residents identified as having a change in condition when the provider was notified of the change in condition and orders for the change in condition were carried out by the direct care staff.

On 06/28/2024, the Administrator audited all residents transferred to the hospital in the last 30 days (05/28/2024 - 06/28/2024) to ensure provider notification was completed for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. The audit identified that provider notification was completed for 22 of 22 residents. No current residents were identified as not having provider notification, therefore no corrective action was required.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed:

On 6/28/2024, Administrator and the Director of Nursing (DON) conducted in service for all full-time, part-time and as needed staff including agency on the abuse/neglect policy for reporting, identifying, and preventing abuse and neglect. All staff (full-time, part-time, and PRN staff,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 34 administration, housekeeping, dietary, nursing, therapy and maintenance) were in-serviced on identifying/reporting abuse/neglect immediately using our abuse policy and procedure. This education was completed in person and by phone. Any staff that was not educated by 6/28/24 will not be allowed to work until education is completed by Administration or department heads. Additionally, on 06/28/2024 the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), Medication Aides and certified nursing assistants (full time, part time, and prn including agency) on the need to notify the provider for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. This education included: types of change in conditions, what to do when a change in condition is noted, who to notify, initiating Emergency Medical Services if needed and importance of providing care and services for any change in condition promptly and if care or services are not provided including not initiating call for Emergency Medical Services for assistance during a medical emergency is neglect. The Interdisciplinary Team (Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Pharmacist),	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 600	Continued From page 35	F 600		

were notified of the allegation of neglect related to facilities failure in following and implementing policy related to abuse/neglect, identifying neglect and addressing change of condition in resident on 06/28/2024 and were involved in the removal plan.

The Administrator and Director of Nurses will ensure that any staff member (full time, part time, and prn including agency) who do not complete the in-service training by 06/28/2024 will not be allowed to work until the training is completed.

This in-service was incorporated into the new employee facility and agency orientation for all staff (full time, part time, and prn including agency) by the Director of Nurses.

Administrator will be responsible for ensuring the removal plan is implemented.

Alleged date of IJ removal 06/29/2024

A validation of immediate jeopardy removal was conducted on 7/3/2024. The initial audit of residents was reviewed, and no issues were noted. Staff interviews across all departments were able to verbalize that they had received education regarding abuse and neglect. The staff were able to verbalize examples of neglect, such as not assessing a resident with a change in condition, not notifying a provider of a change in condition, etc. The staff were able to verbalize what to do if they suspected a resident was being abused or neglected, which included letting the hall nurse know, and following the chain of command if no action was taken. The immediate jeopardy removal date of 6/29/2024 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and Power of Attorney interviews, the facility failed to follow their abuse, neglect, and exploitation policies when they failed to immediately remove a nurse aide (Nurse Aide #10) from the facility following a reported allegation of potential abuse	F 607	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will	7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607

Continued From page 37

involving a resident (Resident #41). This resulted in the facility failing to protect the resident or other residents from potential further abuse. The facility also failed to thoroughly investigate an allegation of misappropriation of resident property involving Resident #26. This occurred for 2 of 4 residents reviewed for Abuse.

The findings included:

1. Review of the facility's policy titled "Abuse Identification" last revised in January 2023 read, in part, under the section, "Taking Steps to Prevent Further Potential Abuse": "The administrator or director of nursing should ensure that steps are taken to prevent further abuse from occurring. These actions may include but are not limited to: Suspending the employee."

Resident #41 was admitted to the facility on 04/08/21 with diagnoses that included Alzheimer's disease with late onset, dementia with behaviors, and cognitive communication deficit.

Review of Resident #41's quarterly Minimum Data Set assessment dated 11/23/23 revealed Resident #41 was cognitively impaired with no delusions, behaviors, or rejection of care.

Review of facility provided allegations of abuse, neglect, or misappropriation revealed Resident #41 was involved in an altercation with Nurse Aide #10 on 01/27/24 in which Nurse Aide #11 heard shouting coming from Resident #41's room and when she arrived, she witnessed Nurse Aide #10 and Resident #41 standing close together and face to face with Nurse Aide #10's hand raised in the air toward Resident #41's face.

F 607

take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. □

F607-Develop/Implement Abuse/Neglect Policies

Corrective action for resident(s) affected by the alleged deficient practice.
For resident# 41, on 1/27/20204 NA #11 provided care to resident #41. On 1/28/2024, NA# 10 was suspended pending investigation.
For resident #26, On 5/20/2024, Administrator submitted investigation report to state reporting agency, notified police, adult protective services.

Corrective action for residents with the potential to be affected by the deficient practice
On 7/8/2024, the Administrator audited grievances for the last 30 days and Resident Council Minutes for any concerns related to allegations of abuse and misappropriation. The results included: There were no grievances or Resident Council Minutes that included any abuse that facility had not addressed per facility policy. Additionally, on 7/10/2024the Administrator reviewed all investigation reports submitted to State Survey Agencies for the past 30 days to ensure any staff identified in an allegation of abuse was suspended immediately per facility policy and investigations related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 38 An interview with Nurse Aide #11 on 06/27/24 at 2:56 PM revealed she was working the evening of 01/27/24 and late in the evening, she heard shouting coming from Resident #41's room. Nurse Aide #11 reported she went to the room and when she walked into the room, she observed Nurse Aide #10 and Resident #41 standing face to face and Nurse Aide #10 had her right arm raised. She stated the way Nurse Aide #10's arm was raised she felt that Nurse Aide #10 was possibly going to put her hand over Resident #41's mouth or potentially strike her. Nurse Aide #11 reported she did not observe Nurse Aide #10 strike Resident #41 or cover her mouth but did ask Nurse Aide if she needed her to take over, to which Nurse Aide #10 replied "no" and then left the room. Nurse Aide #11 stated she stayed with Resident #41 who did not appear to be upset and then went and told her hall nurse, though she could not recall her name. Nurse Aide #11 stated she also could not recall if Nurse Aide #10 worked the rest of her shift or not. Nurse Aide #11 reported she had received training on abuse, neglect, and exploitation and indicated she felt she had followed the policies by reporting what she saw immediately to the nurse. Review of facility provided schedules revealed Nurse #8 was assigned as the hall nurse the night of the incident. Additional review of the facility provided schedules revealed Nurse Aide #10 was scheduled to work 7:00 PM on 01/27/24 until 7:00 AM on 01/28/24. Multiple attempts to reach Nurse #8 by telephone were unsuccessful. An interview with the Administrator on 06/28/24 at 1:28 PM revealed she was the facility's abuse	F 607	misappropriation were investigated according to facility policy. The findings included: No other residents affected by alleged deficient practice. Any staff identified in allegation of abuse was suspended per facility policy. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/8/2024 the Director of Nursing began in-service of all full-time, part-time, and PRN (as needed) staff, administration, housekeeping, dietary, nursing, therapy and maintenance (including agency) on the abuse prohibition/reporting and investigation policy. This training will include all current staff including agency. This training included: Abuse Types, reporting abuse allegations immediately to nurse/DON/Administrator, what to do if abuse observed or suspected, assuring resident safety to include suspension of identified staff involved in alleged abuse and notification of local law enforcement, Adult Protective Services, and State Survey Agency. The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 7/15/2024 will not be allowed to work until the training is completed. The Drector of Nursing will ensure agency staff will be educated prior to working their shift.This training will be included in new hire orientation for any newly hired staff. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 39 coordinator and that she remembered the incident and stated it was her understanding that Nurse Aide #11 observed Nurse Aide #10 raise her hand in the face of Resident #41. When questioned about the reporting timeline, the Administrator reported "it happened back in January, I'm not sure about the timeline" and indicated she believed it was reported shortly after it was observed but stated it could have been the next morning. The Administrator reported she notified Nurse Aide #10, who was still working in the facility at the time, that an allegation of potential abuse had been made against her and that she was suspended pending the outcome of the facility's investigation. The Administrator verified that the facility policy on abuse, neglect, and exploitation included the immediate removal of any staff member who was accused of potential abuse pending the outcome of a full investigation. The Administrator did not have an answer to why Nurse Aide #10 was allowed to finish her shift and again reported she could not recall the timeline following the reported allegation. She indicated that Nurse Aide #10 should have been sent home immediately once Nurse Aide #11 reported the interaction to Nurse #8. 2. Review of the facility's Abuse Identification policy revised 01/2023, read in part, the facility will develop and implement a system for investigating any incident or suspected incident of abuse defined as misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent). All reports of misappropriation of resident property shall be promptly and thoroughly investigated by facility	F 607	and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024, The QA Nurse Consultant or designee will monitor the abuse process to ensure residents are free from abuse and any abuse/misappropriation identified reported and investigated according to facility policy using the QA Tool for F607 Abuse. The Administrator or designee will review all allegations reports to ensure alleged abuse reported and investigated per facility policy. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Unit Support Nurse, Minimum Data Set Coordinator, Social Worker, Therapy Director, Health Information Manager, Maintenance Director and the Dietary Manager. Date of Compliance: 7/16/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 40 management. Resident #26 was admitted to the facility on 04/02/24. Review of Resident #26's admission Minimum Data Set Assessment dated 04/09/24 indicated he was cognitively intact. A review of the facility's Initial Allegation Report, completed by the Administrator and sent to the State Agency on 05/20/24 at 4:39 PM revealed that Resident #26's friend went to the facility on 05/20/24 and reported fraudulent charges had been made on Resident #26's debit card on 05/02/24 to 2 vacation sites and 2 additional charges to a gambling site. The incident was reported to the local police department on 05/20/24 at 8:30 AM and Adult Protective Services (APS) on 05/20/24 at 10:11 AM. A review of the facility's Investigation Report, completed by the Administrator on 05/20/24, revealed the incident resulted in mental anguish because Resident #26 was not able to pay one of his bills but whether the allegation was substantiated was not indicated in the Report. The report stated that all alert and oriented residents would be interviewed by facility leadership on 05/21/24. The facility Scheduler printed off copies of staff who worked the hall where Resident #26 resided from 05/17/24 through 05/20/24 and the Scheduler pulled records for 05/02/24. The Scheduler looked at cameras for 200 hall and did not see anything suspicious. The Investigation Report was submitted to the State Agency on 05/20/24 at 4:39 PM along with the Initial Report.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 41	F 607		

A review of a document titled "Review to Ensure Quality" dated 05/20/24 and completed by the Administrator revealed Resident #26 had cancelled his debit card and was calling his credit card companies to ensure there were no charges on any of his other cards. The document included that as immediate action residents would be asked not to bring anything valuable with them to the facility because there were a lot of people passing through all the time and they did not want anything to be misplaced or stolen. There have been several employees that have worked on the hall where Resident #26 resided since 05/17/24 and most of them have worked at the facility with no issues. There was one employee that the facility did not know well enough, and the Scheduler was looking at video footage of the past couple of days to see if that employee or anyone was hanging around the room where the Resident resided.

A review of an additional document titled "Review to Ensure Quality" dated 05/20/24 revealed a Root Cause Analysis (RCA) statement: On 05/20/24 Resident #26's POA notified the facility of fraudulent charges on his debit card made on 05/02/24. The Resident's wallet with his debit and credit cards were left in his room in his night stand since his admission to the facility on 04/02/24 unsecure while he was at the hospital due to emergent issues. The Residents were advised not to bring anything of value with them during their stay at the facility because there were several people always coming in and out of the building. Some were facility staff which were known to be trustworthy, but some were agency and guests of other residents. On 05/20/24 all residents who were cognitively intact will be interviewed and asked if they had any concerns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 42	F 607		

with misappropriation of property. For the residents with moderately and severely impaired cognition, the grievances and concerns for the last 30 days were reviewed for issues of misappropriation of resident property and there were no concerns identified. On 05/20/24 the interim Director of Nursing began inservicing all full time, part time and as needed staff including agency staff on Abuse (Misappropriation of Resident Property). The document was signed by the Administrator on 05/22/24.

On 06/26/24 at 11:38 AM and 07/02/24 at 12:42 PM interviews were conducted with the Social Worker who reported that on the early morning of 05/20/24 Resident #26's Power of Attorney (POA) brought to her attention a banking statement with fraudulent charges made with the Resident's debit card of approximately 2,000 dollars. The POA stated he believed someone had taken Resident #26's debit card numbers while the Resident kept his debit and credit cards in his wallet in the night stand in his room. The SW stated her initial thought was that someone had taken a picture of Resident #26's debit card while it was in his nightstand because the debit card was accounted for. The SW stated she interviewed residents who were cognitively intact on the hall that Resident #26 resided on about misappropriation of resident property and there were no concerns reported but she did not interview resident families or representatives of residents who had lesser cognition. She stated she did not think about doing that but in retrospect she should have. The SW reported she was unable to interview Resident #26 about the incident after he returned from the hospital because of his altered mental status.

(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 607	Continued From page 43 Interviews were conducted with Resident #26's Power of Attorney on 06/26/24 at 10:30 AM and 06/27/24 at 10:01 AM. The POA explained that after he reported the issue to the facility on 05/20/24 he went to the bank to report the fraudulent charges on Resident #26's debit card and after some research the bank informed him that they identified some unusual activity on the Resident's bank account and that multiple attempts had been made with his on line banking and whoever made the attempts, had his account information and the routing numbers on his checks which was not kept in his night stand. The bank informed him that the charges could have happened from anywhere because whoever made the charges had to have access to his routing numbers and banking information. On 06/28/24 at 12:47 PM and 07/02/24 at 12:55 PM during interviews conducted with the interim Director of Nursing (DON), the DON explained that on 05/21/24 she was asked to interview and educate staff regarding misappropriation of resident property but did not interview about specifics pertaining to Resident #26 debit card charges because she did not know the specifics. She stated she had never investigated anything before, so she picked random staff to interview and educate on misappropriation of resident property but did not keep documentation of her actions. An interview was conducted with the Administrator on 06/26/24 at 12:01 PM. The Administrator explained that on 05/20/24 the Social Worker informed her that Resident #26's POA reported some fraudulent charges had been made on the Resident's debit card account and the Administrator reported the allegation to APS	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 44 and the State Agency. The SW informed the local police department who investigated the allegation. The Administrator continued to explain that Resident #26 was in the hospital at the time the allegation was made on 05/20/24 but that the Social Worker interviewed the Resident when he returned to the facility after 05/21/24. Administrator indicated facility staff from all departments were interviewed by the interim Director of Nursing if they noticed anything out of the ordinary or anyone different going in and out of Resident #26's room and no reports came from those interviews. She stated herself and the Scheduler looked at video footage at areas around the Resident's room and did not see anything abnormal. She indicated they did not interview staff who had worked with Resident #26 in the days leading up to the alleged date of the fraudulent charges (05/02/24). She indicated she did not interview all the staff because she followed the guidance from the corporate staff and did not think all staff should be interviewed. The Administrator reported the SW interviewed alert and oriented residents and they reviewed grievances and concerns filed on behalf of residents with cognitive impairment to see if anyone had reported any issues with misappropriation of resident property and there were no identified concerns from those reviews. The Administrator educated the facility management team and informed them that there were a lot of people in the building and to be careful about bringing items of value into the facility and the management team divided up the residents by halls and educated the residents about bringing valuables into the facility. The Administrator stated she did not indicate on the investigation report if the allegation was substantiated or unsubstantiated because she	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 607	Continued From page 45 was unsure if she was supposed to although she felt it should be unsubstantiated because there were no witnesses to anything that proved Resident #26's banking account routing numbers were taken from the facility or how the account was compromised. During a follow up interview with the Administrator on 07/02/24 at 3:00 PM she was informed the SW revealed during interview that she had not interviewed Resident #26 when he returned from the hospital. The Administrator revealed she was not aware of this information.	F 607		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff	F 644	The statements made on this plan of	7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 644	Continued From page 46 interviews, the facility failed to request a Pre-admission Screening and Resident Review (PASARR) review for a resident who was newly diagnosed with psychosis for 1 of 1 resident reviewed for level II PASARR. (Resident #50) The findings included: Resident #50 was admitted to the facility on 11/01/23 with diagnoses that included depression, and anxiety disorder. Review of Resident #50's quarterly Minimum Data Set assessment dated 05/10/24 revealed her to be moderately impaired with no delusions, behaviors, rejection of care, or instances of wandering. Resident #50 was coded as receiving antipsychotic and antidepressant medication. Resident #50 was coded as receiving antipsychotic medications on a routine basis and that a gradual dose reduction had been attempted and was not clinically contraindicated. Review of Resident #50's medical record revealed a pharmacy review dated 11/10/23 that requested a clarification diagnosis for the use of an antipsychotic. Additionally, the pharmacy review request was addressed by the facility's Nurse Practitioner on 11/01/23 who diagnosed Resident #50 with psychosis and was signed by the facility's Nurse Practitioner. The pharmacy review also had handwritten notes at the bottom that read: "New diagnosis: psychosis via verbal order by [Nurse Practitioner]" initialed off by the Director of Nursing. An interview with the Social Worker on 06/27/24 at 4:53 PM revealed she was the staff member responsible for requesting PASARR reviews at	F 644	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F644 Coordination of PASARR and Assessments Corrective action for resident(s) affected by the alleged deficient practice: On 6/28/2024, the Social Worker submitted through NCMUST. a Preadmission Screening and Resident Review (PASRR) for resident #50. It was submitted and accepted on 6/28/2024. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 7/8/2024, the Social Worker completed 100 % audit of all residents who have had a new psychosis diagnosis assigned to them from 4/1/ 2024 to 7/11/2024, in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who received a new diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation. This was completed on 7/11/2024. No other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 644	Continued From page 47 the facility. The Social Worker explained she would request a PASARR review if a resident at the facility had a change in mental health needs or received a new diagnosis of a serious mental health condition. She reported the facility's mental health provider typically handled diagnosing residents with mental health conditions and would inform her if there was a change in a resident's condition or a new diagnosis of a mental health condition. The SW continued, stating she had not requested a PASARR review for Resident #50 because she was never informed that Resident #50 had been given a new mental health diagnosis of psychosis. She reported she would have expected to have been notified that Resident #50 had been diagnosed with a new mental health condition. An interview with the facility's Nurse Practitioner on 06/28/24 at 11:35 AM revealed she did not know the process for informing other staff of new diagnoses. She stated she felt it was not unusual for her to give residents new diagnoses and stated she did not know what the process was for relaying that information to the Social Worker if it would require a PASARR review. She reported she had diagnosed Resident #50 due to her knowledge of some reported auditory and visual hallucinations and that she felt it was an appropriate diagnosis at the time. An interview with the Director of Nursing was unable to be completed as she was out of the facility and unable to be reached. An interview with the Acting Director of Nursing on 06/28/24 at 11:56 AM revealed the facility's process was once a resident was given a new	F 644	residents affected by alleged deficient practice. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/8/2024, the Nurse Consultant completed education with the facility Social Worker/Admission Coordinator and Health Information Manager which included the PASARR assessment process and requirements for when a level II PASARR is to be completed. The Health Information Manager will notify the Social Worker when a new diagnosis has been added that would potentially qualify for a level II PASARR. On 6/ 28/2024, the Administrator made the Health Information Manager aware of the responsibility of notifying the Social Worker of when a new diagnosis has been added that would potentially qualify a resident for a level II PASARR and made Social Worker aware of responsibility of requesting Level II PASRR reviews when indicated. Any Social Worker, Health Information Manager or Admissions Coordinator who did not receive in-service training by 7/15/2024 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Any newly hired full-time or agency staff will receive this education during orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 644	Continued From page 48 diagnosis, a form was completed and sent to medical records. Medical records would then review the diagnosis and enter the diagnosis in the medical record and upload the form into the medical documents. She stated with Resident #50 it appeared as though the Director of Nursing uploaded the form herself and that she must not have reported the new diagnosis to medical records so they could enter it into the health record of Resident #50. She indicated if the diagnosis had been reported to medical records, then the Social Worker would have been notified and she would have initiated a PASARR review request.	F 644	Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024, The Administrator or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Administrator or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Social Worker, Maintenance Director, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and Dietary Manager. Date of Compliance: 7/16/2024	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		7/16/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 50 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to implement a care plan intervention of placing a rubbery flexible sheet used to prevent sliding to a wheelchair for 1 of 4 residents (Resident #28) reviewed for accidents. The finding included: Resident #28 was admitted to the facility on 11/24/21 with diagnoses that included cerebral vascular accident (CVA) and dementia. The quarterly Minimum Data Set (MDS) assessment dated 02/14/24 revealed Resident #28's cognition was moderately impaired and required moderate assistance with transfers. The MDS indicated the Resident had 2 falls since the last MDS assessment. A review of a progress note dated 04/11/24 read in part, Resident was transferring self from wheelchair to bed and did not lock the brakes causing him slide to the floor and land on his bottom. A review of Resident #28's care plan revised 04/11/24 revealed the Resident had an actual fall with risks of further falls related to poor balance. The goal that Resident #28 would resume usual activities without further incident would be attained by adding a rubbery flexible sheet to prevent sliding in his wheelchair.	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F656 Develop/Implement Comprehensive Care Plan Corrective action Resident #28: On 6/27/2024, Unit Support Nurse placed Dycem to seat of wheelchair per plan of care. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents at risk for falls have the potential to be affected by the alleged practice. On 7/9/2024, an audit will be completed by Director of Nursing to review care plans for all current residents with falls care planned to have Dycem in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 51 A review of Resident #28's medical record revealed an order dated 04/12/24 for a rubbery flexible sheet to prevent sliding to be placed between the Resident's wheelchair and wheelchair cushion and not to be placed between the wheelchair and resident. The order was written by Nurse Supervisor #1. A review of Resident #28's Kardex (a guide for nurse aides to deliver care) dated 06/27/24 included a rubbery flexible sheet to prevent sliding in wheelchair. On 06/27/24 at 4:01 PM an observation of Nurse Aide (NA) #1 and NA #2 was made of transferring Resident #28 from his wheelchair to the commode. There was no rubbery sheet in the Resident's wheelchair which was acknowledged by the NAs. Interviews were conducted at 4:04 PM on 06/27/24 with NA #1 and NA #2 simultaneously. The NA's explained that they mostly worked on the hall that Resident #28 resided on, and reported the Resident had a history of falls. The NAs stated they did not know that he was supposed to have the rubbery sheet in his wheelchair. Both NAs acknowledged the intervention was on his Kardex. An interview was conducted with Nurse Supervisor #1 on 06/28/24 at 9:01 PM who explained that falls were reviewed every morning after the management meeting and interventions were discussed and relayed to the care plan. The Supervisor remembered discussing Resident #28's fall and writing the order for the rubbery sheet to be put in his wheelchair. The Supervisor stated if the intervention was put on the care plan,	F 656	wheelchair as a fall intervention. The results identified 4 of 4 residents observed to have Dycem in wheelchair per plan of care. This was completed on 7/11/2024. Systemic Changes: On 7/8/2024, the Director of Nursing began an in-service education to all full time, part time, and PRN (as needed) including agency licensed nurses (RN, LPN), Medication Aides and Certified Nursing Assistants. Topics included: ¿ The importance for reviewing the Kardex prior to caring for residents and following plan of care ¿ What to do when the device cannot be located. The Director of Nursing will ensure that any of the above identified staff who has not received this training by 7/15/2024 will not be allowed to work until the training is completed. The Drector of Nursing will ensure agency staff will be educated prior to working their shift. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure that the plan of correction is effective and that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 52 then she expected the intervention to be done. The interim Director of Nursing (DON) was interviewed on 06/28/24 at 12:50 PM. The DON explained that falls were discussed in the morning meeting where interventions were decided and put on the care plan. The interim DON stated if the care plan called for the rubbery sheet to be in the Resident's wheelchair, then it should be in his wheelchair.	F 656	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024, the Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Falls Interventions. The monitoring will include reviewing at least 3 residents whose plan of care reflects Dycem to wheelchair to ensure it is in place per plan of care. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved. Quality of Life/Quality Assurance Committee. Reports will be presented to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurse, MDS Coordinator, Human Resource Specialist, Business Office Manager, Health Information Manager, Maintenance Director, Dietary Manager and Social Worker. Date of Compliance: 7/16/2024	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		7/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 53 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to complete and document on-going thorough assessments for an acute change in condition and failed to respond effectively to a medical emergency. On 1/23/2024 at 7:00 pm, Resident #278's Representative requested a chest x-ray, when Nurse #1 observed Resident #278 had a cough, congestion, and decreased appetite. Resident #278 was seen by the NP on 1/24/2024 who ordered an oral medication for breaking up mucous/congestion every 12 hours and nebulizer breathing treatments four times a day were ordered for 7 days for a cough. On 2/2/2024 at 7:00 am, Medication Aide (MA) #1 was told by the off going nurse, Nurse #2, that Resident #278 was not doing well. MA #1 checked Resident #278's oxygen saturation and noted it was in the "high 70's/low 80's" (normal oxygen saturation is 92 to 100%) and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor oxygen saturation levels. MA #1 continued to report breathing issues and concern about Resident #278 struggling to breathe to the DON throughout the day until Resident #278 was removed from the facility by the RR at 4:47 pm. The RR took Resident #278 to the Emergency	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F684 Quality of Care Corrective action for affected residents. Resident #278 had a cough and on 01/23/2024, Nurse #1 notified the provider of resident representative request for a chest x- ray. On 01/24/2024, the provider assessed Resident #278 and did not order a chest x-ray. The facility didn□t perform a chest x-ray requested by Resident #278□s Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider did order Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on 02/02/2024. Resident was assessed for change in condition by Medication Aide #1 with direction from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 684

Continued From page 54

Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on 2/8/2024, received inpatient hospice services in the hospital and expired on 2/12/2024. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents (Resident #278) reviewed for change in condition.

Immediate jeopardy began on 2/2/24 when the facility failed to complete thorough assessments after Resident #278's acute change in condition and respond effectively to a medical emergency. Immediate jeopardy was removed on 6/29/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.

The findings included:

Resident #278 was re-admitted to the facility on 11/1/2023 with a diagnosis of heart disease. Resident #278 did not have a diagnosis of chronic obstructive pulmonary disease (COPD, inflammation of the lungs which causes decreased airflow).

F 684

Director of Nurses. Resident was eventually discharged from the facility on 02/02/2024 to an Acute Care Hospital by the resident representative. The facility failed to provide effective assessments and interventions for a change in condition. The facility failed to effectively respond to a medical emergency.

Corrective action for potentially affected residents.
All residents are at risk of serious harm or death due to the deficient practice. On 06/28/2024, the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite and where emergent care needs can□t be met at the facility. The audit was completed on: 06/28/2024. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684

Continued From page 55

A review of a Medical Orders for Scope of Treatment (MOST) form dated 9/30/2022 revealed Resident #278 was a full code and wished to receive all medical interventions including intubation, advanced airway interventions, mechanical ventilation, cardioversion (a procedure using electricity and medications to convert the heart from an irregular rhythm to a normal rhythm) as indicated, medical treatment, intravenous fluids, and to be transferred to the hospital if indicated.

A review of the Facility Standing Orders, last reviewed on 6/18/2023 by the Medical Director (MD), revealed if a resident experienced shortness of breath, oxygen could be administered at 2 liters/minute and the MD should be notified of a change in condition.

A review of a care plan dated 11/3/2024 revealed Resident #278 had an advanced directive in place and her wishes were to be honored.

An admission Minimum Data Set assessment (MDS) dated 11/8/2023 revealed Resident #278 was cognitively intact with no behaviors, required supervision for bed mobility, transfers, and toileting. Resident #278 was not documented as using oxygen.

A review of a nursing progress note dated 1/21/2024 at 7:29 pm written by Nurse #3 revealed Resident #278 was medicated for a dry cough and had two negative coronavirus (COVID) tests.

An interview was conducted on 6/27/2024 at 5:20 pm with Nurse #3. Nurse #3 stated she worked

F 684

condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite and where emergent care needs can□t be met at the facility.
On 06/28/2024, correction action was completed to include: notification of the provider of the resident change in condition and orders, transfer to ER, X ray, etc. No residents required transfer to an acute care hospital.
Systemic changes
On 06/28/2024 the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on assessment of any acute change in condition including how to respond to change in condition, how to assess a change in condition, when to activate Emergency Medical Services, what to do when a family makes a request to address a change in condition, and the importance of shift to shift report for continuity of care.
The DON will ensure that all licensed nurses, RN□s, LPN□s, and CNA□s (full time, part time, and prn including agency) who do not complete the in-service training by 06/28/2024 will not be allowed to work until the training is completed.
This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency) by the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684

Continued From page 56

day shift (7:00 am to 7:00 pm) on 1/21/2024 and was assigned Resident #278. She reported at that time, Resident #278 had a dry cough, and she performed a COVID test, which had a negative result. Nurse #3 stated she was not able to recall Resident #278 being short of breath at that time.

A review of a provider communication form dated 1/23/2024 at 7:00 pm completed by Nurse #1 revealed Resident #278 presented with a cough, congestion and decreased appetite. Nurse #1 documented Resident #278's RR requested a chest x-ray and for the resident to be seen on 1/24/2024.

A review of the Electronic Health Record (EHR) revealed no documented head to toe assessment on 1/23/2024 by Nurse #1.

A review of the provider notification form dated 1/23/2024 at 7:00 pm revealed Resident #278's vital signs included a blood pressure of 122/57, heart rate of 70 beats/minute, a temperature of 97.3 degrees Fahrenheit, respiration rate of 17 breaths/minute, and oxygen saturation level of 95% on room air. Documentation was completed by Nurse #1.

A review of the Electronic Health Record revealed an assessment dated 1/30/2024 at 3:15 pm which indicated Resident #278 was alert and oriented (to person, time, place, and situation), lung sounds were clear, and a dry cough was noted. Vital signs were documented and revealed a blood pressure of 124/60, heart rate of 63 beats/minute, temperature of 98.2 degrees Fahrenheit, respiration rate of 20 breaths/minute, and oxygen saturation of 93% on room air.

F 684

Quality Assurance
Beginning the week of 7/8/2024, The Administrator or designee will monitor the change of condition process to ensure residents are free from neglect and change of condition addressed according to facility policy using the QA Tool for Neglect/Change of Condition. The Director of Nurses or designee will clinical dashboard and progress notes to ensure change of condition addressed per facility policy. The monitoring will be completed 5 x weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Therapy Director, Health Information Manager, Social Worker, Maintenance Director and the Dietary Manager.
Date of compliance: 7/4/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 57	F 684		

Documentation was completed by Nurse Supervisor #2.

An interview was conducted on 6/27/2024 at 6:04 pm with Nurse #1. Nurse #1 reported she worked on 1/23/2024 during dayshift (7:00 am to 7:00 pm) and was assigned Resident #278. Nurse #1 reported the RR approached her and stated she was worried about Resident #278 because she had been sick a few days, had a cough, and congestion. Nurse #1 reported that she assessed Resident #278 and obtained vital signs. Nurse #1 reported Resident #278 had a lot of congestion but was not having difficulty breathing and was afebrile (not running a fever). Nurse #1 stated she completed the provider communication sheet and placed the completed sheet in the provider communication book at the nurse's station. Nurse #1 stated she had not called the on-call provider on 1/23/2024, because Resident #278's vital signs were stable, and she had not heard any rales or crackles (lung sounds).

A review of Resident #278's progress notes revealed no documentation was written on 1/24/2024 by the Nurse Practitioner (NP).

An interview was conducted on 6/28/2024 at 11:12 am with the NP. The NP reported she had seen Resident #278 on 1/24/2024 per RR request. The NP stated during the visit she had not recalled Resident #278 having any shortness of breath or respiratory distress. The NP stated she noted Resident #278 had a cough and congestion and had not felt like a chest x-ray was warranted at that time. The NP stated she ordered Guaifenesin and Duo-neb treatments to treat the cough and congestion. The NP stated

F 684 Continued From page 58 F 684

she never received any additional notification that Resident #278 had continued to have respiratory issues. The NP stated she had forgotten to finish and sign the note for Resident #278's encounter.

A review of Resident #278's physician orders dated 1/24/2024 at 12:00 pm revealed Resident #278 was prescribed Guaifenesin Extended Release (ER) 600 mg tablet every 12 hours for expectorant for seven days and Duo-neb Solution (nebulizer breathing treatments) to be inhaled orally via nebulizer four times per day for seven days for a cough and was written by the NP.

A review of the Medication Administration Record (MAR) from January 2024 revealed Resident #278 was documented as receiving Guaifenesin ER 600 mg every 12 hours and Duo-nebs four times a day for seven days as ordered.

A review of the Electronic Health Record revealed an assessment dated 1/30/2024 at 3:15 pm which indicated Resident #278 was alert and oriented (to person, time, place, and situation), lung sounds were clear, and a dry cough was noted. Vital signs were documented and revealed a blood pressure of 124/60, heart rate of 63 beats/minute, temperature of 98.2 degrees Fahrenheit, respiration rate of 20 breaths/minute, and oxygen saturation of 93% on room air. Documentation was completed by Nurse Supervisor #2.

An interview was conducted on 6/27/2024 at 5:25 pm with Nurse Aide (NA) #6. NA #6 verified she had been assigned to care for Resident #278 on 1/29/2024 and 1/30/2024 during dayshift (7:00 am to 7:00 pm). NA #6 reported she was unable to recall Resident #278 being sick at that time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684 Continued From page 59 F 684

NA #7 was assigned to care for Resident #278 on 2/1/2024 during night shift (7:00 pm to 7:00 am). NA #7 was unavailable for an interview.

Nurse #12 was assigned to care for Resident #278 on 2/1/2024 during night shift (7:00 pm to 7:00 am). There were no nursing progress notes entered by Nurse #12 on 2/1/2024 from 7:00 pm to 7:00 am.

An attempt was made to contact Nurse #12 on 6/27/2024 and was unsuccessful.

A telephone interview was conducted on 6/27/2024 at 7:30 pm with MA #1. MA #1 reported she worked on 2/2/2024 during dayshift (7:00 am to 7:00 pm) and was assigned Resident #278. MA #1 stated she had just returned to work after being out with Influenza at the end of January 2024. MA #1 stated she received a report from Nurse #2 at 7:00 am and was told by Nurse #2 that Resident #278 was not doing well. MA #1 reported she immediately checked on Resident #278 at 7:00 am and noticed Resident #278 was "struggling with breathing and asking for help." MA #1 reported she obtained an oxygen saturation level in the "low 70's/high 80's" but was unable to recall the exact result. MA #1 stated she immediately got the Director of Nursing (DON) and was instructed to place Resident #278 on oxygen and to continue checking oxygen saturation levels. MA #1 stated the DON went in the room; however, MA #1 was not able to recall the DON performing an assessment. MA #1 reported she placed Resident #278 on 2 to 4 liters/minute, was unable to recall exact amount of oxygen, and routinely checked Resident #278's oxygen level throughout the shift. MA #1 reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ____ B. WING ____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 60 she had not recalled Resident #278's oxygen level rising above 90% at all that day. MA #1 was unable to recall Nurse #11 and was not able to recall asking Nurse #11 for help with Resident #278. MA #1 stated she told the DON multiple times during her shift about Resident #278 struggling to breathe, low oxygen saturation levels, and how she felt Resident #278 "needed to be sent to the hospital" but "no one would listen to her." MA #1 verified she had only reported her concerns for Resident #278 to the DON, and assumed that she would have notified the MD. MA #1 received no response from the DON. MA #1 stated she continued to check Resident #278's oxygen saturation often but was unable to recall getting a full set of vital signs. MA #1 reported she did not check Resident #278's oxygen saturation after the RR arrived and prior to Resident #278 leaving the facility with the RR. MA #1 reported she was passing medications to other residents on the hall at the time Resident #278 was removed from the facility by the RR. Review of the medical record revealed there were no vital signs documented for Resident #278 on 2/2/2024. Nurse #11 was assigned to care for Resident #278 on 2/2/2024 during day shift (7:00 pm to 7:00 am). There were no nursing progress notes entered by Nurse #11 on 2/2/2024. An interview was conducted on 6/27/2024 at 3:05 pm with Nurse #11. Nurse #11 reported she worked as an agency nurse at the facility on 2/2/2024 on dayshift and was assigned Resident #278. Nurse #11 reported she was unable to remember Resident #278 or any events that occurred on 2/2/2024.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 61	F 684		

The DON was unavailable for an interview.

An interview was conducted on 6/27/2024 at 3:07 pm with Nurse Aide (NA) #1. NA #1 stated she worked on 2/2/2024 from 7:00 am to 7:00 pm and was assigned Resident #278. NA #1 stated she was able to remember Resident #278's RR came and got her that day. NA #1 stated Resident #278 had complained about hurting in her chest, "could hardly talk" because she was short of breath and was more tired than usual. NA #1 stated Resident #278 remained in bed on 2/2/2024 and was unable to recall if Resident #278 wore oxygen. NA #1 could not remember if she had taken any vital signs or if Resident #278 had ate/drank anything on 2/2/2024.

A review of a progress note dated 2/2/2024 at 1:44 pm written by Nurse Supervisor #1 revealed she was contacted by Medication Aide (MA) #1 due to Resident #278 having a high blood pressure 235/94 per automatic cuff and 162/84 when taken manually. Resident #278 was out of her blood pressure medication because the RR had not delivered it to the facility. Nurse Supervisor #1 contacted the NP and was advised to wait for the arrival of the blood pressure medications. Nurse Supervisor #1 stated she had called the RR regarding the blood pressure medication and reported the RR was upset and accused the facility of not medicating Resident #278, at which time the RR was asked to speak to the Administrator.

An interview was conducted on 6/27/2024 at 3:57 pm with Nurse Supervisor #1. Nurse Supervisor #1 stated she worked on 2/2/2024. Nurse Supervisor #1 stated Resident #278's RR was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684		F 684		

Continued From page 62
responsible for bringing medications to the facility, because she had not wanted to use the facility's pharmacy. Nurse Supervisor #1 recalled MA #1 had contacted her on 2/2/24 about Resident #278's high blood pressure and not having blood pressure medication available at that time. Nurse Supervisor #1 stated she contacted the NP and was advised to wait on the RR to bring the medication. Nurse Supervisor #1 reported she had not gone to assess Resident #278 because she was never informed by MA #1 that Resident #278 was having difficulty breathing.

A review of a progress note dated 2/2/2024 at 2:08 pm written by Nurse Supervisor #1 revealed Resident #278's RR had still not brought medication to the facility and the RR alleged the facility had deliberately not administered Resident 278's medications for three days. The Nurse Supervisor had called to inform the RR, the RR became upset and accused the facility of not medicating Resident #278, and the RR was then transferred via phone to the Administrator.

A review of a progress note dated 2/2/2024 at 4:47 pm written by the Social Worker (SW) revealed Resident #278's RR came to the facility on 2/2/2024 and removed Resident #278 from the facility. The SW documented the RR was upset regarding medications and felt they could no longer leave Resident #278 in the facility. The SW assisted the RR in the room with packing her belongings and provided them with copies of her paperwork and medication list. The RR was given the leftover bottles of medications because the RR had provided those. The SW asked the RR to take an oxygen tank with them due to her oxygen levels had been falling at times, but they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ____ B. WING ____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 63	F 684		

refused and stated they were going straight to the Emergency Room from the facility and declined the offer. The RR refused to wait for proper discharge on 2/2/2024 at 4:47 pm.

An interview was conducted on 6/27/2024 at 2:10 pm with the SW. The SW reported that when the RR arrived, she went to the room with her to pack up Resident #278's belongings. The RR stated Resident #278 was "really sick" and they were going to take her straight to the Emergency Department. The SW stated Resident #278 had been having respiratory issues for a few days and had received treatment for respiratory symptoms. The SW stated she observed Resident #278 to be "sleepy and appeared out of it" prior to the RR's arrival at the facility. The SW stated she accompanied the RR to Resident #278's room, Resident #278 was "easily aroused" but appeared "very sick." The SW recalled MA #1 was in the process of calling the on-call provider when the RR arrived due to concern over Resident #278's breathing and was concerned that the respiratory issues had progressed to pneumonia. The SW stated she informed the RR that MA #1 was calling the MD, but the RR insisted on removing Resident #278 from the facility anyway. The SW stated the RR refused to wait on proper discharge paperwork and refused to take an emergency oxygen tank with them. The SW stated she assisted Resident #278 to the RR's vehicle via wheelchair and buckled her in the car on 2/2/2024 at 4:47 pm.

A follow-up interview was conducted on 6/28/2024 at 11:41 am with the SW. The SW reported she had walked down 400-hall and remembered MA #1 stating Resident #278 "was not doing very good and did not look good"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 64	F 684		

around 11:30 am. The SW stated she asked MA #1 if she had notified anyone. The SW stated MA #1 had told her Resident #278's oxygen saturation levels were dropping, and that MA #1 had placed Resident #278 on oxygen and that Resident #278 had maintained oxygen levels between 84-90% afterwards. The SW stated she went in the room and observed Resident #278 on oxygen and stated she looked sick. The SW stated after she left the room, she immediately went to talk to the DON but was met near the front entrance of the facility by the RR. The SW reported she had not been able to speak with the DON prior to Resident #278 was removed from the facility on 2/2/2024 at 4:47 pm by the RR. The SW verified the DON had not gotten to assess Resident #278 when the RR arrived. The SW was unable to explain the lapse in time between when she noticed Resident #278 "looked sick" and when she was going to speak with the DON at 4:47 pm.

An interview was conducted on 6/27/2024 at 4:27 pm with the Resident #278's Representative (RR). The RR stated they would not go into details about the event when Resident #278 was removed from the facility but stated Resident #278 had been taken to the hospital, diagnosed with the flu, and later died, and stated "it all could have been prevented." The RR refused to answer any additional questions.

A review of the Emergency Department (ED) records dated 2/2/2024 revealed Resident #278 presented to the hospital for evaluation of cough, congestion, and shortness of breath and had no respiratory history of chronic obstructive pulmonary disease or chronic respiratory illnesses. Vital signs on arrival to the ED were

F 684 Continued From page 65 F 684

blood pressure of 157/74, heart rate of 77 beats per minute, 18 breaths per minute, temperature of 98 degrees Fahrenheit, and an oxygen saturation of 92%. The ED record did not specify if Resident #278 was on oxygen or room air in the ED. The RR stated Resident #278 had a cough and congestion for 2 weeks and they had asked for Resident #278 to be evaluated at the facility and felt like "she had been neglected." Resident #278 reported weakness, cough, congestion, sore throat, and pleuritic pain (chest pain that gets worse with breathing). Resident #278 had an elevated white blood cell count (which indicated infection) of 14.4, a blood urea nitrogen (BUN) level of 24 (indicating mild dehydration), tested positive for Influenza A and received Decadron (a steroid used to reduce inflammation), intravenous fluid bolus (to improve dehydration), and a Duo-neb treatment. Resident #278 was admitted to the hospital with a diagnosis of Influenza A and Influenzal Bronchitis.

A hospital progress note dated 2/2/2024 at 9:32 pm revealed Resident #278 was wheezing, had rhonchi (gurgling or bubbling sounds), and had an oxygen saturation in the upper 80's. Resident #278 was placed on 2 liters of oxygen per min via nasal canula.

A hospital nursing note dated 2/4/2024 at 7:47 pm revealed Resident #278 struggled to maintain an oxygen saturation greater than 91% and supplemental oxygen had to be increased to 4 liters of oxygen per minute via nasal canula. Resident #278 complained of a sore throat, bright red blood in sputum, and had a chest x-ray that showed pneumonia. Resident #278 was placed on Vancomycin (antibiotic used to treat a broad spectrum of infections) and Rocephin (antibiotic).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 66	F 684		

A hospital communication and patient planning note dated 2/7/2024 revealed Resident #278 was on 6 liters of oxygen per minute via nasal canula.

A review of the Acute Hospital Death Summary dated 2/12/2024 at 5:55 pm revealed Resident #278 had presented to the hospital on 2/2/2024 with acute hypoxemic respiratory failure, tested positive for Influenza A and had a superimposed bacterial infection with Methicillin-resistant Staphylococcus aureus (MRSA, an infection resistant to many antibiotics) positivity. Resident #278 had right lower lobe consolidation (which indicates pneumonia), had received Vancomycin (antibiotic used to treat a wide variety of infections) and Rocephin (antibiotic used to treat respiratory tract infections). Resident #278 had increased oxygen requirements throughout her hospitalization and the infection continued to progress causing mucous plugging (mucous that builds up in the lungs and reduces the flow of air). Due to Resident #278's weak cough and debility, the RR placed Resident #278 on comfort measures and Resident #278 received inpatient hospice services in the hospital and died on 2/12/2024 at 5:55 pm with the RR at bedside.

A review of a Certificate of Death dated 2/20/2024 revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia.

An interview was conducted on 6/27/2024 at 6:19 pm with the Infection Preventionist (IP). The IP stated there had been no Influenza or COVID outbreaks so far in 2024. The IP was unable to find any Influenza testing results for Resident #278.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 67	F 684		

An interview was conducted on 6/27/2024 at 4:40 pm with Nurse Supervisor #2. Nurse Supervisor #2 reported she had worked with Resident #278 a few times and remembered that she had been lying in bed more often and she had a cough. She stated Resident #278 was tested for Influenza and COVID at the facility around 2/2/2024, however she was not able to locate the order for Influenza testing or test results. Nurse Supervisor #2 stated if Resident #278 had been having upper respiratory infection symptoms, nursing assessments should have been completed at least weekly or with breathing treatments. Nurse Supervisor #2 stated the last documented nursing assessment, according to the Electronic Health Record (EHR), was in December of 2023. Nurse Supervisor #2 reported she was not sure why an assessment had not been documented since then, and reported an assessment should have been performed if there was a change in condition or if the resident had experienced respiratory infection symptoms.

An interview was conducted on 6/28/2024 at 11:12 am with the NP. The NP stated she never received any notification on 2/2/2024 that Resident #278 had any respiratory issues or had required the use of oxygen for low oxygen saturation levels and reported the assigned staff member should have notified a medical provider.

A telephone interview was conducted on 6/27/2024 at 4:16 pm with the MD. The MD stated he had cared for Resident #278 at the facility and reported she had been slowly "dwindling" and spending more time in bed since admission. The MD reported Resident #278 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 68	F 684		

no significant medical illnesses. The MD stated he was not aware that Resident #278 had been taken to the Emergency Department on 2/2/2024 after the RR removed her from the facility where she subsequently expired. The MD reported he had not been made aware of any respiratory issues or low oxygen saturation levels and that a medical provider should have been notified because Resident #278 may have needed to be transferred to the hospital.

An interview was conducted on 6/27/2024 at 2:35 pm with the Administrator. The Administrator reported she had spoken to the RR on 2/2/2024 about concerns regarding medications. The Administrator reported Resident #278 had not been sick but that the RR had come and removed her because of issues with medications and the RR accusing the facility of not medicating Resident #278. The Administrator reported she was not aware Resident #278 had been transferred to the hospital on 2/2/2024 and later expired.

The Administrator was made aware of Immediate Jeopardy on 6/28/2024 at 9:48 am.

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

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

Resident #278 had a cough and on 01/23/2024, Nurse #1 notified the provider of resident representative request for a chest x- ray. On 01/24/2024, the provider assessed Resident #278 and did not order a chest x-ray. The facility didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684 Continued From page 69 F 684

perform a chest x-ray requested by Resident #278's Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider ordered Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on 02/02/2024. Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on 02/02/2024 to an Acute Care Hospital by the resident representative. The facility failed to provide effective assessments and interventions for a change in condition. The facility failed to effectively respond to a medical emergency.

All residents are at risk of serious harm or death due to the deficient practice. On 06/28/2024, the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite and where emergent care needs can't be met at the facility.

The audit was completed on: 06/28/2024. The audit identified that 2 of 79 residents had an acute change in condition to include: Any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 70	F 684		

symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite and where emergent care needs can't be met at the facility. On 06/28/2024, correction action was completed to include notification of the provider of the resident change in condition and orders, transfer to ER, X ray, etc. No residents required transfer to an acute care hospital.
Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed:

On 06/28/2024 the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on assessment of any acute change in condition including how to respond to change in condition, how to assess a change in condition, when to activate Emergency Medical Services, what to do when a family makes a request to address a change in condition, and the importance of shift to shift report for continuity of care.

The DON will ensure that all licensed nurses, RN's, LPN's, and CNA's (full time, part time, and prn including agency) who do not complete the in-service training by 06/28/2024 will not be allowed to work until the training is completed.

This in-service was incorporated into the new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 684	Continued From page 71 employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency) by the Director of Nursing. Alleged date of IJ removal 06/29/2024 A validation of immediate jeopardy removal was conducted on 7/3/2024. The initial audit of residents was reviewed, and no issues were noted. Staff interviews across all departments were able to verbalize that they had received education on notification of change in condition, examples of change in condition, who to notify of a change in resident condition, etc. Non-nursing staff were able to verbalize examples of a change in condition and the appropriate steps to take in notification, including the hall nurse, Director of Nursing, Administrator, and medical provider. Nursing staff were able to verbalize steps to be taken when a resident was observed with a change in condition which included a thorough head to toe assessment, complete set of vital signs, assessment and vital sign documentation, and notification of a provider/initiation of Emergency Medical Services (EMS). The immediate jeopardy removal date of 6/29/2024 was validated.	F 684		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 690	Continued From page 72 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Resident, staff, Nurse Practitioner (NP), and Medical Director (MD) the facility failed to have a documented diagnosis for the use of an indwelling urinary catheter (Resident #18) and facility failed to prevent urinary catheter bags from touching the floor to reduce the risk of infection (Resident #48) for 2 of 2 residents (Resident #18 and Resident #48) reviewed for urinary catheter.	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 690	Continued From page 73 The findings included: 1) Resident #18 was admitted to the facility on 2/13/2024 with no urinary diagnosis. A review of the physician's orders 2/13/2024 revealed an order for Resident #18 was to have an indwelling urinary catheter removed and replaced with a new catheter every 21 days and as needed for leaking or occlusion and was signed by the Medical Director (MD). A review of a history and physical note dated 2/19/2024 completed by the MD revealed Resident #18 was admitted from the hospital due to a necrotic (dead tissue) lesion on his right foot which required amputation. Resident #18 was noted to have a wound vac. Resident #18 was not documented as having a urinary catheter. The MD documented Resident #18 had hematuria. A review of the Treatment Administration Record from February 2024 to June 2024 revealed documentation that Resident #18 had his indwelling urinary catheter changed every 21 days as ordered. A quarterly Minimum Data Set (MDS) assessment dated 5/22/2024 revealed Resident #18 was moderately cognitively impaired with no behaviors and was documented with an indwelling catheter. A review of a care plan dated 5/20/2024 revealed Resident #18 had an indwelling urinary catheter. An observation was conducted on 6/26/2024 at	F 690	deficiencies cited have been or will be corrected by the dates indicated. F690 Bowel/Bladder Incontinence, Catheter, UTI Corrective action for resident(s) affected by the alleged deficient practice: Resident #18: On 6/26/2024, MD notified and order given to remove Foley catheter Resident #48: On 6/25/2024 NA#5 corrected deficient practice by readjusting bed to prevent urinary drainage bag from touching floor. On 6/28/2024 NA#6 corrected deficient practice by attaching urinary drainage bag to bed rail and raising bed to prevent drainage bag from touching floor Corrective Action for Potentially Affected Residents. All residents in the facility who currently have a Foley Catheter have the potential to be affected by the alleged deficient practice. On 7/11/2024, the Unit Support Nurses audited all current residents with a Foley catheter to ensure they had an appropriate diagnosis for use. No other residents identified with an inappropriate diagnosis for Foley catheter use. Additionally, the Unit Support Nurses made visual observations of all residents with an indwelling catheter to ensure urinary drainage bag was not touching the floor. The observations identified no urinary drainage bags touching the floor. This was completed by 7/11/2024. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/8/2024, the Director of Nursing began an in-service education to all full time, part time, and PRN (as needed)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 690 Continued From page 74

12:26 pm Resident #18 had a urinary catheter hanging from the right-hand side of the bed. The urine in the catheter drainage collection bag was dark yellow with sediment (causes urine to be cloudy, white blood cell accumulation).

An interview was conducted on 6/26/2024 at 2:30 pm with Resident #18. Resident #18 stated he had a catheter for "a while" and was unsure of why he had one.

An interview was conducted on 6/26/2024 at 3:54 pm with Nurse #4. Nurse #4 reported was assigned Resident #18. Nurse #4 stated when a resident had a catheter, there should be an order. Nurse #4 stated she was not sure why Resident #18 had a urinary catheter and verified there was no diagnosis that would support a urinary catheter on Resident #18's Electronic Health Record (EHR).

An interview was conducted on 6/26/2024 at 5:10 pm with Nurse Supervisor #2. Nurse Supervisor #2 reported when a resident was admitted to the facility, an order should be in place for a urinary catheter if there is a supporting diagnosis. Nurse Supervisor #2 stated Resident #18 was admitted to the facility with a urinary catheter, and it had never been removed. Nurse Supervisor #2 verified there was no diagnosis in Resident #18's EHR to support the use of an indwelling urinary catheter.

An interview was conducted on 6/27/2024 at 4:19 pm with the MD. The MD stated a resident should have a supporting diagnosis such as urinary obstruction or retention for the use of an indwelling urinary catheter. The MD stated facility staff had contacted him on 6/26/2024 regarding

F 690

licensed nurses (RN, LPN), Medication Aides and Certified Nursing Assistants including agency. Topics included:
" Foley Catheter care to include infection control by not allowing catheter drainage bag to touch floor
" Ensuring resident has appropriate diagnosis for Foley catheter and what to do if resident is admitted with a Foley catheter without an appropriate diagnosis

The Director of Nursing will ensure that any of the above identified staff who has not received this training by 7/15/2024 will not be allowed to work until the training is completed. The Drector of Nursing will ensure agency staff will be educated prior to working their shift. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained.
Quality Assurance-
Beginning the week of 7/22/2024, The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Monitoring Foley Catheters. The monitoring will include reviewing a sample of residents with order for Foley catheter to ensure they have an appropriate diagnosis and urinary drainage bag is not touching the floor. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 690	Continued From page 75	F 690		

Resident #18's urinary catheter and he could not find where an indwelling urinary catheter was warranted and ordered for the catheter to be removed.

An interview was conducted on 6/28/2024 at 11:27 am with the Nurse Practitioner (NP). The NP stated a resident should have a supporting diagnosis such as urinary retention for the use of an indwelling urinary catheter. The NP stated there was no actual diagnosis to support the use of an indwelling urinary catheter for Resident #18.

An interview was conducted on 6/28/2024 at 12:23 pm with the Interim Director of Nursing (DON). The Interim DON stated there should be an order for an indwelling urinary catheter with a urinary diagnosis. The Interim DON reported she was made aware on 6/26/2024 that Resident #18 had an indwelling urinary catheter without a urinary diagnosis and the urinary catheter was removed.

#2. Resident #48 was admitted to the facility on 01/04/23 with diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms, and severe hydronephrosis of right kidney.

Review of Resident #48's significant change Minimum Data Set assessment dated 05/11/24 revealed him to be moderately impaired with no rejection of care. Resident #48 was coded as having an indwelling urinary catheter.

Review of Resident #48's physician orders revealed the following order:
- Indwelling urinary catheter size for severe

Provider's Plan of Correction (F 690, continued):

of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurse, Minimum Data Set Coordinator, Business Office Manager, Health Information Manager, Human Resources Specialist, Dietary Manager, Social Worker and Maintenance Director.
Date of compliance: 7/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 690		F 690		

Continued From page 76
hydronephrosis of right kidney; placed catheter during surgery. Catheter not to be removed until urology follow-up.

An observation completed on 06/25/24 at 2:31 PM revealed Resident #48 to be in his room, in bed. Resident #48's bed was observed to be lowered to the floor which resulted in his urinary drainage bag resting on the floor and folding over on itself. Nurse Aide (NA) #5 came in the room and covered Resident #48, walked around his bed and did not address the urinary drainage bag on the floor.

An interview with NA #5 on 06/25/24 at 2:35 PM revealed she did not notice the urinary drainage bag was on the floor and indicated she would raise the bed to keep it off the floor.

Another observation of Resident #48 completed on 06/28/24 at 8:34 AM revealed Resident #48 to be in his bed with his bed in the lowest position. An observation of Resident #48's urinary drainage bag revealed it to be detached from the bed and was lying flat on the floor.

An interview with NA #6 on 06/28/24 at 8:35 AM revealed she was assigned to Resident #48. NA #6 verified she had provided care to Resident #48 earlier that morning. NA #6 also reported urinary drainage bags should not rest on the floor and that it was the responsibility of nurse aides and nurses to ensure that urinary drainage bags were off the floor.

An observation of Resident #48's urinary drainage bag with NA #6 on 06/28/24 at 8:35 AM revealed it to be detached from his bed and was resting on the floor. NA #6 reported his urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY** **BLOWING ROCK, NC 28605**

(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 690	Continued From page 77 drainage bag should be attached to his bed and not in contact with the floor. NA #6 proceeded to hang the urinary drainage bag on Resident #48's bed and then raise his bed up until the urinary drainage bag was not in contact with the floor. During an interview with the Acting Director of Nursing on 06/28/24 at 12:04 PM, she reported when a resident was in bed, it was her expectation that the urinary drainage bag be hung securely to the bed and if a resident was required to be in a low positioned bed, that their bed be lowered to the point where it kept the urinary drainage bag off the floor. She stated there was no reason for Resident #48's urinary drainage bag to not be attached to his bed and be left laying flat on the floor.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have cautionary oxygen signage posted (Resident #15) and failed to keep an oxygen concentrator free from dust and debris (Resident #37) for 2 of 3 residents reviewed for respiratory care.	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 695

Continued From page 78

The findings included:

1. Resident #15 was admitted to the facility on 05/21/24 with diagnoses that included heart failure.

The admission Minimum Data Set assessment dated 05/28/24 revealed Resident #15's cognition was severely impaired, and she required supplemental oxygen.

A review of Resident #15's medical record revealed an order dated 05/28/24 for the hall nurse to wean oxygen via nasal cannula to maintain oxygen saturation above 92%.

On 06/25/24 at 1:02 PM during an observation of Resident #15, the Resident wore supplemental oxygen via nasal cannula at 0.5 liters per minute. There was no oxygen cautionary sign posted on or near the Resident's door to indicate oxygen was in use.

Subsequent observations of no cautionary sign posted on or near Resident #15's door on 06/26/24 at 2:56 PM and 06/26/24 at 4:22 PM.

An interview was conducted with Nurse #6 on 06/26/24 at 4:22 PM. The Nurse explained that all residents with oxygen should have oxygen cautionary signs posted on their doorframe to their rooms and as many times that she had been in and out of Resident #15's room, she never noticed there was no sign posted on her doorframe.

During an interview made with Nurse Supervisor #2 on 06/26/24 at 5:10 PM the Supervisor explained that all residents who wore oxygen

F 695 (Plan of Correction)

plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F695 Respiratory/Tracheostomy Care and Suctioning

Corrective action for resident(s) affected by the alleged deficient practice:
Resident #15: On 6/26/2024, Nurse Supervisor #2 placed Oxygen in Use sign on door.
Resident#37: On 6/27/2024, Unit Manager #1 removed and cleaned concentrator filter and replaced in concentrator
Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 7/11/2024, the Director of Nursing and Unit Support Nurses began auditing all current residents receiving oxygen. Oxygen Concentrator filters were observed for dust buildup and doors of residents receiving oxygen therapy were checked to ensure Oxygen in Use signage was posted. Any concentrator filter identified as needing cleaning was removed, cleaned and replaced. Any door of resident receiving oxygen therapy noted without Oxygen in Use signage had sign placed on door. This was completed by 7/12/2024

Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 7/8/2024, the Director of Nursing and Nurse Consultant began education to all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 695	Continued From page 79 should have cautionary oxygen signs posted on their doorframe to indicate a fire hazard because oxygen was in use. She stated the oxygen signs should be posted when the resident was admitted to the facility. On 06/28/24 at 12:50 PM an interview was conducted with the interim Director of Nursing (DON) who explained the cautionary oxygen sign should be posted on the residents' door by the admitting nurse and if the resident transferred rooms, then the transferring nurse should post the sign. She stated that periodically, she would assign audits for the signs to be done but there had not been an audit done in a while. The interim DON stated there should be cautionary signs posted on all doors that have oxygen in use in the rooms. 2. Resident #37 was admitted to the facility on 11/01/23 with diagnoses that included hypertensive heart disease and congestive heart failure. A review of Resident #37's quarterly Minimum Data Set assessment dated 05/10/24 revealed she was coded as receiving oxygen therapy while a resident. Review of Resident #37's physician orders revealed the following orders: - Oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath. Use when oxygen saturations are 90% or less on room air. - Clean oxygen concentrator filter once a week - every day shift, every Monday for oxygen use. An observation of Resident #37 completed on 06/25/24 at 11:14 AM revealed her to be in bed	F 695	full time, part time, and PRN (as needed) Licensed Nurses, Medication Aides and Certified Nursing Assistants including agency on the following: Oxygen Administration/Signage This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training by 7/15/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024, he Director of Nursing or designee will monitor compliance utilizing the F695 Quality Assurance Tool. Monitoring will include observing a sample of 5 resident receiving oxygen therapy to ensure concentrator filters are cleaned as ordered and Oxygen in Use signage is posted on door. The monitoring will be completed weekly x 4 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 695 Continued From page 80

resting with oxygen being provided via nasal cannula. An observation of Resident #37's oxygen concentrator at this time revealed the filter to be caked with white dust around the intake and filter.

An additional observation of Resident #37's oxygen concentrator was completed on 06/27/24 at 11:22 AM revealed the concentrator to continue to have a thick amount of white dust built up on the intake and filter.

Review of Resident #37's medication administration record (MAR) revealed Nurse #7 signed the MAR as having completed the cleaning of Resident #37's oxygen filter on 06/25/24.

Multiple attempts to reach Nurse #7 via telephone and text were unsuccessful.

An interview with NA #8 revealed she believed that the facility had a service company that came into the facility every so often and serviced the oxygen concentrators. She reported that it was her understanding that the service company would change the filters and repair any issues noted with the operation of the oxygen concentrators. She also reported she felt that the hall nurses were responsible for ensuring that the concentrators remained clean and free from dust and debris between the scheduled service.

An interview with Nurse #8 on 06/28/24 revealed she was an agency nurse and that she had worked in the facility approximately 3 shifts. She also reported she had nothing to do with the cleaning of oxygen concentrators and ensure they were free of dust and debris. She reported she

F 695

initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, Social Worker, Human Resources Specialist, Maintenance Director and the Dietary Manager.

Date of Compliance: 7/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 695	Continued From page 81 had no knowledge of who was responsible for that task and assumed it was the unit managers. An interview with Unit Manager #1 on 06/28/24 at 12:50 PM revealed it was her understanding that service and cleaning of oxygen concentrators was the responsibility of the Maintenance Director. She stated he would be the facility staff member responsible for ensuring that oxygen concentrators were clean from dust and debris. An interview with the Maintenance Director on 06/28/24 at 12:54 PM revealed he coordinated with the service company the facility used to provide routine and emergency maintenance to the facility's oxygen concentrators. He further stated that he has nothing to do with the daily cleaning of the facility's oxygen concentrators. The Maintenance Director reported he did not know who was responsible for the daily cleaning of oxygen concentrators. An interview with the Acting Director of Nursing on 06/28/24 at 11:54 AM revealed she believed it was the responsibility of night shift staff to ensure that oxygen concentrator filters were clean and free from dust and debris. She reported the facility typically had standing orders in each resident's medical record to ensure the oxygen concentrators were clean and free from dust and debris. She also stated she expected oxygen concentrator filters to be clean and that there should be no build up of dust on them.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F 697		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 697	Continued From page 82 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, Resident Representative (RR), staff, Nurse Practitioner (NP) interviews, the facility failed to address a resident's pain after a resident requested pain medication and was observed "screaming in pain, crying, and very upset" by Nurse #10 on 2/6/2024. The deficient practice occurred for 1 of 3 residents (Resident #279) reviewed for pain. The findings included: Resident #279 was admitted to the facility on 1/30/2024 with a diagnosis of left artificial knee joint replacement. A review of a physician's order dated 1/30/2024 revealed an order for Resident #279 to be administered oxycodone (pain medication) 10 milligrams (mg) every four hours as needed for pain for 5 days. The order expired on 2/5/2024. A review of a physician's order dated 1/30/2024 revealed an order for Resident #279 to be administered acetaminophen (pain medication) 1000 mg, every four hours as needed for general discomfort). A review of the January and February 2024 Medication Administration Record (MAR) revealed documentation that Resident #279 received oxycodone 10 mg on 2/1/2024 at 1:02 am (pain 8 out of 10) and 8:14 am (pain 2 out of 10); 2/2/2024 at 10:17 pm (pain 7 out of 10);	F 697	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F697-Pain Management Corrective action for resident(s) affected by the alleged deficient practice: For resident #279, on 2/7/2024 the Nurse Practitioner wrote order to restart Oxycodone 10mg every 6 hour as needed and Nurse #3 administered medication as ordered. Pain assessment for resident was 0 of 10. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning 7/11/2024, the Director of Nursing and QA Nurse Consultant audited 100% of all current residents with orders for as needed narcotic pain medication to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 697 Continued From page 83

2/3/2024 at 10:05 am (pain 8 out of 10); and on 2/4/2024 at 10:02 am (pain 5 out of 10) and 9:25 pm (pain 6 out of 10).

An admission Minimum Data Set (MDS) assessment dated 2/6/2024 revealed Resident #279 was cognitively intact with no behaviors.

A review of a nursing progress noted dated 2/6/2024 at 8:40 pm, written by Nurse #10, revealed Resident #279 had requested oxycodone (pain medication) and there was not an active order for oxycodone (the order expired on 2/4/2024). Resident #279 was sitting on the side of the bed and grabbed the sides of her hair, began screaming, and demanded stronger pain medication than acetaminophen. The on-call provider was notified and advised staff to discuss the need for pain medication with the facility provider. No new orders for pain medication were received.

A review of a pain assessment dated 2/6/2024 at 9:00 pm revealed Resident #279 had a pain level of 10 out of 10.

A review of the February 2024 MAR revealed documentation that Resident #279 received acetaminophen 1000 mg on 2/6/2024 at 9:00 pm from Nurse #10.

An interview was conducted on 6/27/2024 at 11:17 am with Nurse #10. Nurse #10 stated she worked night shift (7:00 pm to 7:00 am) and was assigned Resident #279 on 2/6/2024. Nurse #10 stated Resident #279 had requested oxycodone for pain, that she previously had been prescribed. Nurse #10 stated she checked Resident #279's active orders, and the order for oxycodone had

F 697

ensure medication was not administered due to no active order and ensure MD was notified and order given to reinstate order. The results identified no other resident affected by alleged deficient practice. This was completed on 7/12/2024.

Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 7/8/2024, the Director of Nurses (DON) began educating the Medical Director, Nurse Practitioner and all Licensed Nurses (Registered Nurses, Licensed Practical Nurses), full time, part time and PRN (as needed) including agency on the following topics:

- Pain Management and what to do if unable to get order from on-call provider to include notifying medical director or nurse practitioner for order
- Professional Standards
- Narcotic Process

Additionally, on 7/11/2024 the QA Nurse Consultant educated the facility Medical Director and the Nurse Practitioner that they will need to be available to address any concerns related to medication administration including obtaining orders which are not addressed by the on-call provider.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345045	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 07/03/2024
NAME OF PROVIDER OR SUPPLIER: THE FOLEY CENTER AT CHESTNUT RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE: 621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605	

(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 697	Continued From page 84 expired. Nurse #10 stated Resident #279 started "screaming in pain, crying, and was very upset." Nurse #10 stated she had contacted the on-call medical provider, name unknown, and requested an order for pain medication. Nurse #10 stated the on-call medical provider told her that Resident #279's pain medications would have to be obtained by a facility provider the following day. Nurse #10 stated Resident #279 continued to cry in pain for the remainder of her shift and stated she placed a communication sheet in the medical provider book to obtain a new order for pain medication. Nurse #10 reported she had checked on Resident #279 throughout the shift and assessed her for pain. Nurse #10 stated she had administered acetaminophen to Resident #279, but that Resident #279 continued to have pain. Nurse #10 stated she had not used ice, the night of 2/6/2024, on Resident #279's left knee. Resident #279 was unavailable for an interview. An interview was conducted on 7/2/2024 at 12:27 pm with Nurse Aide (NA) #3. NA #3 reported she was assigned Resident #279 on 2/6/2024 during dayshift (7:00 am to 7:00 pm). NA #3 stated she was not able to recall Resident #279. An attempt to interview NA #4, that was assigned Resident #279 on 2/6/2024 during night shift (7:00 pm to 7:00 am) was unsuccessful. An interview was conducted on 6/27/2024 at 12:09 pm with Nurse #3. Nurse #3 reported she worked on 2/7/2024 on dayshift (7:00 am to 7:00 pm) and was assigned Resident #279. Nurse #3 stated she remembered Resident #279 had a knee replacement surgery but was unable to recall Resident #279 complaining of pain.	F 697	all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above identified staff who does not receive scheduled in-service training by 7/15/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024, the DON or designee will monitor compliance utilizing the F697 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The Director of Nursing will monitor compliance by reviewing 5 residents weekly to ensure resident pain needs addressed. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, Social Worker, Maintenance Director, Business Office Manager, and the Dietary Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 697	Continued From page 85	F 697	Date of Compliance: 7/16/2024	

An interview was conducted on 6/27/2024 at 11:25 am with the Nurse Practitioner (NP). The NP stated she had seen Resident #279 following a knee replacement. The NP stated she had issues with pain following her surgery. The NP stated she was aware the on-call provider had refused to order pain medication for Resident #279 during night shift on 2/6/2024 and reported she felt like the on-call provider should have given a "one time order for pain medication" to get the resident through the night until a facility provider could evaluate Resident #279 the next day. The NP stated she had noticed on-call providers were hesitant to prescribe pain medications and would often refer the staff to the regular facility providers. The NP stated she had written an order for Resident #279's oxycodone on 2/7/2024.

A review of a physician's order dated 2/7/2024 at 6:00 pm revealed an order for Resident #279 to be administered oxycodone 10 mg every six hours as needed for pain for 7 days.

A review of the February 2024 MAR revealed documentation that Resident #279 received oxycodone 10 mg at on 2/7/2024 6:00 pm (pain 0 out of 10) from Nurse #3.

An interview was conducted on 6/27/2024 at 12:37 with Resident #279's Representative (RR). The RR stated Resident #279 was admitted to the facility following knee replacement surgery. The RR stated shortly after Resident #279 had issues getting pain medications and staff continued to tell her there were no orders for pain medication. The RR stated Resident #279 reported she was in "pretty bad pain at times."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 697	Continued From page 86 An interview was conducted on 6/28/2024 at 12:18 pm with the Interim Director of Nursing (DON). The Interim DON stated she was aware of Resident #279 requesting pain medication on 2/6/2024. The Interim DON reported Nurse #10 had contacted on-call for a one-time pain medication order, and the on-call provider instructed Nurse #10 to have the regular facility provider order pain medication. The Interim DON reported this was not typical of the on-call providers and stated she had no explanation for why the provider had not ordered any pain medication.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 755	Continued From page 87 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Nurse Practitioner (NP) interviews the facility failed to re-order medications from the pharmacy to ensure medications were available for 1 of 3 residents (Resident # 52) reviewed for the provision of pharmaceutical medications to meet residents' needs. The findings included: Resident #52 was admitted to the facility on 2/7/2023 with a diagnosis of type 2 diabetes. A review of a physician's order dated 4/12/2024 revealed Resident #52 was to be administered Humulin N Kwikpen (intermediate acting insulin, used to lower blood sugar levels) 8 units subcutaneously (injection) two times per day for diabetes, with instructions to hold if resident's blood sugar was less than 150 milligrams per deciliter (mg/dL). A quarterly Minimum Data Set (MDS) assessment dated 5/17/2024 revealed Resident #52 was moderately cognitively impaired and had no rejections of care. Resident #52 was documented as having received 1 insulin injection	F 755	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-755 Servcs/Procedures/Pharmacists/Records Corrective action for resident(s) affected by the alleged deficient practice: Resident# 279: On 6/22/202, Humulin N ordered from pharmacy and delivered at 8pm. Nurse #8 administered 8 units of Humulin N. on policies related to medication errors/ missed medications, medication ordering process and notification of MD related to medication availability. Corrective action for residents with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 755 Continued From page 88
during the 7 day look back period and was documented as having "0" number of days the physician changed the resident's insulin order during the 7 day look back period. Resident #52 was coded for hypoglycemic medications (medication used to increase a low blood sugar).

A review of the June 2024 MAR revealed Resident #52 had not received Humulin N Kwikpen 8 units subcutaneously on 6/22/2024 at 4:30 pm due to the medication not being available by Nurse #8.

A review of Resident #52's blood sugar levels revealed a reading of 200 mg/dL on 6/22/2024 at 4:55 pm.

A review of a nursing progress note completed by Nurse #3 dated 6/22/2024 at 6:26 pm revealed the on-call provider was notified that Resident #52's Humulin N Kwikpen was not in stock, provider was to call Nurse #3 back. The on-call pharmacist was notified that Humulin N Kwikpen would be needed the night of 6/22/2024.

A review of a nursing progress note dated 6/22/2024 at 8:22 pm completed by Nurse #8 revealed Resident #52 had not received insulin and was in route for delivery from the pharmacy.

An interview was conducted on 6/26/2024 at 4:32 pm with Nurse #3. Nurse #3 stated she worked 6/22/2024 on dayshift (7:00 am to 7:00 pm). Nurse #3 stated a Medication Aide, name unknown, informed her Resident #52 was out of insulin and there was no Humulin N Kwikpen's in the emergency medication back up. Nurse #3 stated she called the on-call medical provider and had to leave a message for them to return her

F 755

potential to be affected by the deficient practice: All current resident receiving medications have potential to be affected. On 7/11/2024 the Director of Nursing audited 100% of resident medication administration records with orders for insulin for the past 14 days for missed medication due to med unavailable. Once it was determined who had missed medications due to medication not being available, MD was notified and orders updated to hold if not stored in Pyxis per MD and medication reordered from pharmacy for same day delivery. This was completed by 7/15/2024.

Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/11/2024 the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses (RN, LPN), Medication Aides, including agency staff on the following topics: Medication administration process to assure that medications are provided to residents per medical order and steps to take if a medication is not available to include notifying provider and Orders Management Policy and Procedure. The Director of Nursing will ensure that any licensed Nurse or Medication Aide (full-time, part-time, agency, or PRN) who has not received this training by 7/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in¿ service refresher courses for all staff identified above and will be reviewed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 755	Continued From page 89 call, and stated she called the emergency pharmacy and ordered more insulin that was to be delivered later that night. Nurse #3 stated she left her shift shortly after speaking with the emergency pharmacy and was unsure if Resident #52 received insulin later that night. An interview was conducted on 7/2/2024 at 2:11 pm with Nurse #8. Nurse #8 reported he worked 6/22/2024 on night shift (7:00 pm to 7:00 am) and was assigned Resident #52. Nurse #8 reported he had been informed by the off-going Nurse that Resident #52 was out of insulin and there was none in back up. Nurse #8 stated he called the emergency pharmacy, and they delivered the medication around 8:00 pm, at which time he administered Resident #52's ordered dose of insulin. Nurse #8 stated he had forgotten to document the administration of Resident #52's insulin at 8:00 pm. An interview was conducted on 6/28/2024 at 12:13 pm with the Interim Director of Nursing (DON). The Interim DON stated when a resident was running low on a medication, the Nurse should reorder the medication through their Electronic Health Record (EHR). The Interim DON stated if a resident was out of medication, the Nurse should pull the medication from the emergency backup. The Interim DON was unsure if Humulin N was kept in back up and stated facility staff should have ordered additional insulin when Resident #52 was observed to be low on insulin.	F 755	the Quality Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 7/22/2024, the Director of Nursing or designee will monitor compliance utilizing the Missed Medication Quality Assurance Tool to ensure insulin is given as ordered and if unavailable, staff are adhering to facility policy related to obtaining medications. The monitoring will be completed weekly x 4 weeks then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, Maintenance Director, Social Worker, and the Dietary Manager Date of Compliance: 7/16/2024	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 759	Continued From page 90 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to maintain a medication error rate of less than 5% by having 10 errors out of 25 opportunities which resulted in a 40% medication error rate. This affected 1 of 11 residents observed on medication pass (Resident # 286). The findings included: A review of Resident #286's 6/27/2024 active physician's orders revealed the following: - Prednisone (steroid medication) 10 milligrams (mg) tablets, 2 tablets by mouth one time a day for COPD. - Buspirone HCL (anxiety medication) 15 mg tablets, 2 tablets by mouth three times a day for anxiety. - Sertraline (depression and/or anxiety medication) HCL 100 mg tablets, 2 tablets by mouth one time a day for depression. - Levothyroxine Sodium (thyroid hormone medication) 150 micrograms (mcg) tablet once a day for hypothyroidism. - Hydralazine HCL (medication used to treat high blood pressure) 50 mg tablet by mouth two times a day for hypertension (high blood pressure). - Amlodipine Besylate (blood pressure medication) 10 mg tablet once a day for hypertension, hold if systolic (top number of blood pressure reading) is less than 120 mm/hg.	F 759	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-759 Free of Medication Error Rts 5 Prcnt or More Corrective action for resident(s) affected by the alleged deficient practice: Resident #286- On 6/27/2024, after being made aware of medication error, Nurse #5 retrieved resident #286 medication and administered meds as ordered. Resident was assessed by QA Nurse Consultant with no acute distress noted. MD notified with no new orders. QA Nurse Consultant immediately reeducated Nurse #5 related to medication errors and 6 rights of medication administration. Additionally, Quality Assurance Nurse Consultant completed medication pass observation with Nurse #5 with no issues noted. Medication error report was completed for resident #286.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 759

Continued From page 91

- Senna 8.6 mg tablet by mouth once a day for constipation.
- Omeprazole Magnesium 20 mg tablet by mouth once a day for heartburn.
- Guaifenesin 100 mg/5 ml Oral Syrup, 20 ml by mouth four times a day for COPD.
- Cyanocobalamin (vitamin B-12) 500 mcg tablet, 2 tablets once a day for a supplement.

An observation was conducted on 6/27/2024 at 10:14 am of Nurse #5 preparing Resident #50's medications. The medications that were prepared included aspirin (prevents blood clots from forming) 81 mg tablet, apixaban (blood thinner) 2.5 mg tablet, lactulose 15 ml oral solution, Lisinopril (blood pressure medication) 20 mg, senna (stool softener) 1 mg tablet, sertraline 25 mg tablet, tramadol (pain medication) 50 mg tablet, loratadine (allergy medication) tablet, and quetiapine (treats mood and behavior disorders) 25 mg tablet and Cranberry Supplement 450 mg tablet.

An observation was conducted on 6/27/2024 at 10:25 am of Nurse #5 taking Resident #50's medications to Resident #286's bedside. Nurse #5 told Resident #286, she had brought her morning medications and handed her the medication cup. Resident #286 proceeded to ask Nurse #5 what medications she was getting this morning and Nurse #5 reported she was unsure, and that she would have to go look and come back. Nurse #5 took the medications from Resident #50's hand and brought her computer to the bedside. Nurse #5 proceeded to hand Resident #286 the cup of medication while proceeding to say, "okay {name of Resident #50}, you will be taking aspirin, a cranberry pill," and was stopped by Resident #286 when she asked,

F 759

Corrective action for residents with the potential to be affected by the deficient practice:
All resident receiving medications have potential to be affected by the alleged deficient practice. Beginning 07/8/2024, the Director of Nursing and Unit Managers completed random medication administration observations with licensed nurses and medication aides to validate staff competency with medication administration. The results of the audit were shared with the physician. The observations identified all staff observed as following the 6 rights of medication administration during medication pass. This was completed on 7/15/2024

Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 7/10/2024 the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses Registered Nurses (RN) and Licensed Practical Nurses (LPN), and medication aides including agency staff on the following topics: Prevention of medication errors and Following the 6 rights of medication administration. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled- in-service training by 7/15/2024 will not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 759	Continued From page 92 "what did you say my name was?" Nurse #5 replied "{name of Resident #50)." Resident #286 stated, "that is not me, you have the wrong person." Nurse #5 replied "what do you mean, you have the wrong person? Are you not {name of Resident #50}?" Resident #286 stated, "no I am {name of Resident #286}." Nurse #5 removed the cup from Resident #286 and left the room. Nurse #5 administered Resident #286's correct medications. An interview was conducted on 6/27/2024 at 10:33 am with Nurse #5. Nurse #5 reported she worked as an agency nurse in the facility. Nurse #5 stated residents should be verified by their name and date of birth prior to administering medications. Nurse #5 stated she was going to ask Resident #286 her name and date of birth and reported Resident #286 had intervened before should was able to. Nurse #5 stated she should have verified the resident's name and date of birth prior to handing her the cup of medication. An interview was conducted on 6/27/2024 at 10:37 with the Interim Director of Nursing (DON). The Interim DON reported prior to administering medications, the Nurse should verify the right resident, right medication, right dose, right route, right date, and right time. The Interim DON stated Nurse #5 was an agency nurse and had just started working at the facility. The Interim DON stated Nurse #5 should have known to verify the rights of medication administration prior to attempting to give Resident #286 her medication. An interview was conducted on 6/27/2024 at 1:02 pm with the NP. The NP stated "several things	F 759	allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 7/22/2024, The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F 759 Med Pass QA monitoring tool. Monitoring will include observing medication pass following the 6 rights of medication administration for 1 medication aide and 1 nurse weekly for 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Social Worker, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Business Office Manager, Maintenance Director and the Dietary Manager. Date of Compliance: 7/16/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 759	Continued From page 93 could have happened if Resident #286 had received apixaban without a diagnosis of atrial fibrillation (irregular heart rate). She could have had bleeding." The NP stated, "you should know the possible adverse effects of receiving the wrong medications" and refused to answer further questions. The NP stated the encounter was "not a medication error because Resident #286 had not received the medication." An interview was conducted on 6/27/2024 at 4:21 pm with the MD. The MD stated medications should be given to the resident that they are ordered for. The MD was made aware of the observations on the medication pass with Resident #286.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to verify medication rights of administration, including right resident and right medication, when a nurse attempted to administer Resident #50's medications (including apixaban, a blood thinner) to Resident #286 for 1 of 11 residents reviewed for significant medication error (Resident #286). The findings included: Resident #286 was admitted to the facility on 6/21/2024 with a diagnosis of Chronic Obstructive	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-760 Residents are Free of Significant	7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 760	Continued From page 94 Pulmonary Disease (inflammation of the lungs that decreases airflow), hypertension (high blood pressure), depression, anxiety, restlessness/agitation, acute embolism/thrombosis (blood clot) of a deep vein in the lower extremity, gastric ulcers. An admission Minimum Data Set (MDS) assessment dated 6/28/2024 was incomplete. An observation was conducted on 6/27/2024 at 10:14 am of Nurse #5 preparing Resident #50's medications. The medications that were prepared included aspirin (prevents blood clots from forming) 81 mg tablet, apixaban (blood thinner) 2.5 mg tablet, Lisinopril (blood pressure medication) 20 mg, tramadol (pain medication) 50 mg tablet, and quetiapine (treats mood and behavior disorders) 25 mg tablet. An observation was conducted on 6/27/2024 at 10:25 am of Nurse #5 taking Resident #50's medications to Resident #286's bedside. Nurse #5 told Resident #286, she had brought her morning medications and handed her the medication cup. Resident #286 proceeded to ask Nurse #50 what medications she was getting this morning and Nurse #5 reported she was unsure, and that she would have to go look and come back. Nurse #5 took the medications from Resident #50's hand and brought her computer to the bedside. Nurse #5 proceeded to hand Resident #286 the cup of medication while proceeding to say, "okay {name of Resident #50}, you will be taking aspirin, a cranberry pill," and was stopped by Resident #286 when she asked, "what did you say my name was?" Nurse #5 replied "{name of Resident #50)." Resident #286 stated, "that is not me, you have the wrong	F 760	Med Errors Corrective action for resident(s) affected by the alleged deficient practice: Resident #286- On 6/27/2024, after being made aware of medication error, Nurse #5 retrieved resident□s medication and administered meds as ordered. Resident was assessed by QA Nurse Consultant with no acute distress noted. MD notified with no new orders. QA Nurse Consultant immediately reeducated Nurse #5 related to medication errors and 6 rights of medication administration. Additionally, Quality Assurance Nurse Consultant completed medication pass observation with Nurse #5 with no issues noted. Medication error report was completed for resident #286. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected by the alleged deficient practice. Beginning 07/10/2024, the Director of Nursing and Unit Managers completed random medication administration observations with licensed nurses and medication aides to validate staff competency with medication administration. The results of the audit were shared with the physician. The observations identified all staff observed as following the 6 rights of medication administration during medication pass. This was completed on 7/15/2024. Measures /Systemic changes to prevent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 760	Continued From page 95 person." Nurse #5 replied "what do you mean, you have the wrong person? Are you not {name of Resident #50}?" Resident #286 stated, "no I am {name of Resident #286}." Nurse #5 removed the cup from Resident #286 and left the room. An interview was conducted on 6/27/2024 at 10:33 am with Nurse #5. Nurse #5 reported she worked as an agency nurse in the facility. Nurse #5 stated residents should be verified by their name and date of birth prior to administering medications. Nurse #5 stated she was going to ask Resident #286 her name and date of birth and reported Resident #286 had intervened before should was able to. Nurse #5 stated she should have verified the resident's name and date of birth prior to handing her the cup of medication. An interview was conducted on 6/27/2024 at 10:37 with the Interim Director of Nursing (DON). The Interim DON reported prior to administering medications, the Nurse should verify the right resident, right medication, right dose, right route, right date, and right time. The Interim DON stated Nurse #5 was an agency nurse and had just started working at the facility. The Interim DON stated Nurse #5 should have known to verify the rights of medication administration prior to attempting to give Resident #286 her medication. An interview was conducted on 6/27/2024 at 1:02 pm with the NP. The NP stated "several things could have happened if Resident #286 had received apixaban without a diagnosis of atrial fibrillation (irregular heart rate). She could have had bleeding." The NP stated, "you should know the possible adverse effects of receiving the wrong medications" and refused to answer further	F 760	reoccurrence of alleged deficient practice: On 7/10/2024 the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses Registered Nurses (RN) and Licensed Practical Nurses (LPN), and medication aides including agency staff on the following topics: Prevention of medication errors and Following the 6 rights of medication administration. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled-in-service training by 7/15/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning the week of 7/22/2024, The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F 760 Med Pass QA monitoring tool. Monitoring will include observing medication pass following the 6 rights of medication administration for 1 medication aide and 1 nurse weekly for 4 weeks, then monthly x 2 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 760	Continued From page 96 questions. The NP stated the encounter was "not a medication error because Resident #286 had not received the medication." An interview was conducted on 6/27/2024 at 4:21 pm with the MD. The MD stated medications should be given to the resident that they are ordered for. The MD was made aware of the observations on the medication pass with Resident #286. The MD stated the medication that could have had an adverse outcome for Resident #286 would have been apixaban. The MD stated Resident #286 could have experienced unexpected bleeding.	F 760	weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Social Worker, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Business Office Manager, Maintenance Director and the Dietary Manager. Date of Compliance: 7/16/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 812	Continued From page 97 Based on observations and staff interviews, the facility failed to label and date open food items and discard items that were beyond their expiration date in 1 of 1 walk in refrigerators and 2 of 3 reach in refrigerators in the kitchen. The findings included: On an initial tour of the facility's kitchen on 06/25/24 at 10:17 AM, an open gallon of whole milk with a sell by date of 06/23/24 located in a reach-in refrigerator. An observation of the facility's 2nd of 3 reach-in refrigerators revealed open and undated package of American cheese slices and ¼ block of open and undated butter with portions of the butter open to air. The cheese was wrapped in cellophane while the butter was in the original paper wrapping that was simply folded over the used end of the butter block. During a follow-up visit to the kitchen on 06/27/24 at 11:58 AM an observation of the walk-in refrigerator revealed an open and undated bag of shredded mozzarella cheese with a use by date of 06/09/24. An interview with the Dietary Manager on 06/27/24 at 12:01 PM she reported she goes through the refrigerators twice a week on Mondays and Thursdays to check for any open and undated food items or for any food items past their used by date or are expired. She stated that she expected her dietary staff to also check the refrigerators, freezers, or dry storage on Mondays and Fridays and remove any food items that are at or past their expired or used by date along with any food items that are opened and undated. She also explained that she expected her staff to	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 For dietary services, a corrective action was obtained on 6/25/2024 and 6/27/2024. During initial walk through of the kitchen on 6/25/2024 and revisit on 6/27/2024, it was noted dietary services had failed to properly label, date, and discard out of date items. On 6/25/2024 cheese in the reach-in noted without label/date, out of date milk not discarded in the walk-in cooler, and pasta without label/date noted in dry storage. On 6/27/2024 during temperature and trayline observation, a bag of cheese found without label/date and past best by date noted in walk-in cooler. On 6/25/2024 and 6/27/2024 the Dietary Manager discarded items. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 6/27/2024, the Dietary Manager and Dietitian completed a walk-through and review of all storage areas in the kitchen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 812	Continued From page 98 always label and date any food items they open before they are stored away. An interview with the Administrator on 06/28/24 at 12:49 PM revealed she expected food items to be removed at their expiration date and that she expected the dietary staff to always label and date opened food items before they are stored away.	F 812	to ensure all food items were within their dates and dated properly. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 7/8/2024 by the Dietitian and Dietary Manager. Topics included: " Storage and dating policy. " Shift inspections to observe all food are within their dates and tossed if out of date. " Use by Dates of common food items and where to find use by dates. Inspections on each shift to review all storage areas to ensure all food is labeled, dated, and stored properly. Food items left in original boxes (as appropriate) when received from truck to better track dates. Use by Date Posters posted. Magnetic dating stations added through-out the kitchen in the main food storage areas. Any staff who does not receive scheduled-in-service training by 7/15/2024 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance monitoring procedure. Beginning the week of 7/22/2024, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 812	Continued From page 99	F 812	Administrator or designee will monitor procedures for proper food storage weekly x 4 weeks then monthly x 2 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and stored properly in the kitchen and in the nourishment rooms. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Social Worker, Maintenance Director and the Dietary Manager Date of Compliance: 7/16/2024	
F 842 SS=D	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	F 842		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 100 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 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.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 101 §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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed maintain complete and accurate medical records by not ensuring the Nurse Practitioner completed a progress note after seeing a resident related to cough congestion and decreased appetite for 1 of 2 residents (Resident #278) reviewed for medical record accuracy. The findings included: A review of a provider communication form dated 1/23/2024 at 7:00 pm completed by Nurse #1 revealed Resident #278 presented with a cough, congestion and decreased appetite. Nurse #1 documented Resident #278's Resident Representative (RR) requested a chest x-ray and for the resident to be seen on 1/24/2024. A review of Resident #278's progress notes revealed no documentation was written on 1/24/2024 by the Nurse Practitioner (NP). An interview was conducted on 6/28/2024 at	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: On 6/28/2024, the Nurse Practitioner corrected resident # 278 medical record to reflect encounter with resident on 1/24/2024. The Medical Director was notified that resident # 278 encounter note was not uploaded to resident□s electronic medical record per facility policy. QA Nurse consultant verbally reeducated Nurse Practitioner related to uploading encounter visit notes in resident medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 102 11:12 am with the Nurse Practitioner (NP). The NP reported she had seen Resident #278 on 1/24/2024 per RR request at which time she noted Resident #278 had a cough and congestion and had not felt like a chest x-ray was warranted at that time. The NP stated she ordered Guaifenesin (oral medication for breaking up mucous/congestion) and Duo-neb (breathing treatment medication given through a nebulizer) treatments to treat the cough and congestion. The NP stated she had forgotten to finish and sign the note for Resident #278's encounter which is why the documentation was not in Resident #278's Electronic Health Record (EHR). An interview was conducted on 6/28/2024 at 12:13 pm with the Interim Director of Nursing (DON). The Interim DON stated when a medical provider assesses a resident, a provider progress note should be in the EHR only if it was completed and signed. The Interim DON stated she had been made aware the NP had seen Resident #278 on 1/24/2024 and had not written/signed a note. The Interim DON verbalized a note should have been completed, signed, and uploaded into the medical record. An interview was conducted on 6/28/2024 at 12:01 pm with the Administrator. The Administrator stated anytime a resident was seen by a medical provider in there facility there should be an accompanying signed note with each encounter. The Administrator was not aware the NP had seen Resident #278 on 1/24/2024 and not completed, signed, and uploaded a progress note into the EHR.	F 842	record timely. Corrective action for residents with the potential to be affected by the deficient practice: All residents have potential to be affected by the deficient practice. On 7/9/2024 the QA Nurse Consultant and Director of Nursing reviewed MD communication forms and electronic medical record for the past 14 days of current residents to ensure encounter notes uploaded to resident electronic medical record. Any electronic medical record noted without encounter note not uploaded from Medical Director or Nurse Practitioner related to encounter visit was corrected in the resident record. This was completed by 7/15/2024. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/11/2024 the Quality Assurance Nurse Consultant educated the Medical Director and Nurse Practitioner on the following topics: Accuracy of resident records and timely documentation in the resident□s medical record. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees. Any of the above identified staff who does not complete education by 7/15/2024 will not be allowed to work until education is completed. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 103	F 842	and/or in compliance with regulatory requirements. Beginning the week of 7/22/2024 The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F 842 QA Tool for monitoring resident records in a weekly Quality assurance (QA) meeting. Monitoring will include reviewing 5 resident medical records to ensure encounter progress notes are documented in chart following encounter per policy. This will be completed weekly x 4 then monthly x 2 months or until resolved. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinator, Therapy Manager, Social Worker, Maintenance Director, Health Information Manager, and the Dietary Manager. Date of Compliance: 7/16/2024	
F 880 SS=D	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	F 880		7/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 104	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 105 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to implement their handwashing/hygiene policy as part of their infection control program when Nurse #7 did not perform hand hygiene when changing gloves during wound care or change gloves after removing a soiled dressing from Resident #15. The facility also failed to implement their policy for Enhanced Barrier Precautions (EBP) regarding donning Personal Protective Equipment (PPE) to include donning gloves and gowns during high contact resident care activities. Two staff were observed checking Resident #15's brief for incontinence and were not wearing gowns or gloves during the incontinence check. These failures occurred for 1 of 3 residents (Resident #15) reviewed for infection control. The findings included: a. A review of the facility's Hand Hygiene policy as part of their Infection Control program revised 10/2022. Under policy indications for Hand	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 INFECTION CONTROL Corrective action for affected residents. *For resident #15- On 6/27/2024 Resident assessed by DON. No acute distress. MD notified with no new orders. Nurse #7 verbally reeducated related to hand hygiene during wound care For resident #15- On 6/26/2024 Resident assessed by DON. No signs or symptoms of infection noted. MD notified of deficient practice. Nurse #6 and NA #3 were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 106 Hygiene read in part: *If hands are not visibly soiled, use an alcohol-based hand rub for routine decontaminating. *Use hand hygiene after direct contact with resident's skin. *After contact with bodily fluids or excretions, non-intact skin, wound dressings. *After removing gloves. *Before and after performing dressing care of touching wounds of any kind. *After handling used dressings. An observation of wound care was conducted on 06/27/24 at 11:40 AM by Nurse #7. The Nurse washed her hands and donned PPE of gloves and a gown. She exposed the resident's left heel that had a stage III pressure ulcer which was covered with a border dressing that was saturated with a moderate amount of brown drainage. Nurse #7 removed and discarded the saturated dressing in the trash can then removed her gloves and without washing her hands or using hand sanitizer the Nurse donned a clean pair of gloves. She then cleansed the left heel wound with wound cleanser spray and a single gauze pad then picked up the cleaning solution and poured the solution in a clear plastic cup and put a gauze pad in the solution to soak the gauze with the solution. Nurse #7 then removed the soaked gauze from the cup and squeezed out the excessive solution and placed the gauze against the left heel wound and covered the gauze with a border dressing. The Nurse then removed her gloves and donned a new pair of gloves without using hand sanitizer or washing her hands. The Nurse then dated the border dressing and replaced the resident's sock.	F 880	verbally reeducated related to Enhanced Barrier Precaution policy. Corrective Action for Potentially Affected Residents. All current residents and staff have potential to be affected by deficient infection control practices. On 7/9/2024 and 7/10/2024, the Director of Nursing and Unit Manager completed Infection Control Rounds on all halls to determine if deficient practices noted related to hand hygiene and donning of appropriate PPE prior to care for residents on Enhanced Barrier Precautions. The audits identified all staff observed following infection control policy related to hand hygiene and donning/doffing PPE. The Director of Nursing began education with all direct care staff on hand hygiene and utilizing proper PPE for Enhanced Barrier Precautions. Systemic Changes On 7/8/2024, the Director of Nursing began education on hand hygiene and utilizing appropriate PPE for all full-time, part-time, PRN (as needed) Registered nurses, Licensed practical nurse, medication aides, nursing aides and therapy department staff including agency. The Drector of Nursing will ensure agency staff will be educated prior to working their shift. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 107

On 06/27/24 at 2:13 PM an interview was conducted with Nurse #7 who explained she was an agency nurse who had been coming to the facility for years. The Nurse stated no management staff had audited her wound care technique, but she had been with supervisors before while performing wound dressing changes and had never been corrected on her technique. Nurse #7 acknowledged she did not wash or sanitize her hands when she changed her gloves and stated she did not know she was supposed to wash her hands in between glove changes and she did not know she should change her gloves after she removed the soiled dressing and after she cleaned the wound. The Nurse stated she was nervous while being watched during the procedure.

An interview was conducted with Nurse Supervisor #2 on 06/27/24 at 5:45 PM. The Supervisor explained that she rounded with the wound physician weekly and monitored the wounds along with the physician. The Supervisor indicated that hands should be washed or sanitized before and after donning and doffing gloves and after removing an old dressing, after cleansing the wound and before placing the new treatment to the wound. The Supervisor stated handwashing was a nurse thing and every nurse should know when to do it.

During an interview with the interim Director of Nursing (DON) on 06/28/24 at 1:03 PM the interim DON explained that she was new at the position and did not know how often or if the nurses were audited for proper technique in wound care dressing changes. She indicated her expectation was for the nurse to sanitize her

F 880

identified staff who does not receive scheduled- in-service training by 7/15/2024 will not be allowed to work until training has been completed.
Quality Assurance
Beginning the week of 7/22/2024, the Director of Nursing or designee will observe and monitor hand hygiene during wound care and donning/doffing PPE for Enhanced Barrier Precautions prior to performing care. Monitoring will include reviewing 5 residents weekly for 4 weeks then monthly x 2 months to ensure that proper hand hygiene and personal protective equipment use is occurring per facility policy. QA Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director.
Date of Compliance: 7/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 108	F 880		

hands after removing dirty gloves and donning clean gloves and she expected change their gloves after removing the old dressing and after cleaning the wound.

b. A review of the facility's Enhanced Barrier Precautions as part of their Infection Control program revised 03/2024 revealed in part:

Under Policy: It is the policy of this facility to use EBP based on guidance from the Centers for Disease Control (CDC). Enhanced barrier precautions expand use of Personal Protective Equipment beyond situations in which exposure to blood and body fluids is anticipated. Enhanced precautions refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi drug resistant organisms to staff hands and clothing.

Applies to all residents with the following:
*Wounds or indwelling medical devices.

Examples of high contact resident care activities requiring enhanced barriers:
*Incontinence care
*Wound care

On 06/26/24 at 2:56 PM Nurse #6 and Nurse Aide (NA) #3 were observed going into Resident #15's room to provide incontinent care. The Resident's door was marked with EBP signs posted outside the door and a drawer set was parked inside the door stocked with PPE available for use. The EBP signage was marked with directions to use gowns and gloves when rendering high contact resident care activities such as: changing briefs and assisting with toileting. Nurse #6 did not don gown or gloves and the NA only donned gloves

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605

(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 109	F 880		

after which both staff positioned the Resident to her left side. The Nurse proceeded to unfasten the Resident's brief to determine if the Resident was wet or soiled. The Nurse stated the Resident was dry and did not need to have her brief changed at that time. Both staff then repositioned the Resident to her back and left the room.

An interview was conducted with Nurse #3 on 06/26/24 at 4:22 PM who explained that she knew the Resident was on EBP, but she thought she only had to wear the PPE if she was going to change the Resident's wound dressing and not for the purpose of changing her brief.

During an interview with Nurse Aide #3 on 06/26/24 at 4:35 PM the NA explained that she was aware of EBP sign posted on Resident #15's door and thought the Resident was under the EBP because she had a urinary catheter. She continued to explain that she knew the Resident's catheter had been removed and thought the facility had not taken the EBP sign down and taken the PPE away yet and that was why she only wore gloves.

An interview was conducted with Nurse Supervisor #3 on 06/26/24 at 5:18 PM who explained that there were multiple indications for a resident to be under EBP and having a urinary catheter and a wound were indications for the precautions. The Supervisor reported Resident #15 did have a urinary catheter that was recently removed, and the Resident did have a current wound so the EBP should have been honored and the correct PPE should have been worn. The Supervisor stated her expectation was for the PPE to be worn no matter if the facility had not removed the signage yet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345045	A. BUILDING ______ B. WING ______	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOLEY CENTER AT CHESTNUT RIDGE	**621 CHESTNUT RIDGE PARKWAY BLOWING ROCK, NC 28605**

(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 110	F 880		

During an interview with the interim Director of Nursing (DON) on 06/28/24 at 1:03 PM the interim DON explained that she expected the staff to follow the directions on the EBP signage if it was posted outside the resident's door no matter what the reason the precautions were indicated for.

An interview was conducted with the Administrator and the Regional Nurse Consultant on 06/28/24 at 4:03 PM. The Nurse explained that Nurse #7 should have washed or sanitized her hands between glove changes, and she should have changed her gloves when she moved from a dirty to clean procedure during the wound care process. The Nurse also indicated that staff should don the appropriate PPE if the EBP signage was posted on the door.