STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted from 7/1/24 through 7/2/24. The following intakes were investigated NC00218407 and NC00218123. Six of the eight complaint allegations resulted in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §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	F 550		7/26/24

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

Electronically Signed | 07/19/2024

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F 550	Continued From page 1 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 subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews, the facility failed to provide incontinence care when Resident #2 requested incontinence care before attending an activity. This failure caused Resident #2 to miss the activity when she remained in her room in a soiled and wet brief. This made the Resident feel very upset, angry and cry. This occurred for 1 of 2 sampled residents reviewed for dignity and respect. The findings included: The admission date for Resident #2 to the facility was 11/6/15. The 8/2/23 annual Minimum Data Set (MDS) assessment recorded it was very important to Resident #2 to attend her favorite activities. Resident #2's care plan, revised November 2023 indicated bowel and bladder incontinence and depressive episodes. The care plan recorded that Resident #2 may exaggerate events, make false claims and allegations at times. Interventions included encouraging effective communication, checking for incontinence, providing peri-care	F 550	F550 Resident #2 was observed in the dining room on 7/2/2024 well-groomed and dry. Current residents that require staff assistance with toileting needs were audited for timely incontinent care by the Director of Nursing on 7/2/24. On 7/2/24 to 7/5/24 the Director of Nursing initiated staff education to the nursing department to cover timeliness of incontinence care in order to attend activities. The facility will educate all new employees on hire. As needed training will continue with all staff. The Director of Nursing or designee will conduct random audits related to incontinent care three times a week for four weeks then weekly for four weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings	

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F 550	Continued From page 2 after each incontinent episode, modifying daily schedule to accommodate community life participation as requested by the resident and encouraging participation in activities of choice. Resident #2's most recent MDS assessment dated 5/1/24 recorded adequate hearing, adequate vision, with corrective lenses, clear speech, understood, understands, intact cognition, required substantial to maximum toileting hygiene assistance, frequent bladder incontinence, and always incontinent of bowel. A 6/7/24 grievance recorded by the Activity Director indicated that on 6/7/24, Resident #2 turned on her call light at 1:47 PM and requested Nurse Aide (NA) #1 assist her with incontinence care but had to wait. The investigation findings recorded that NA #1 was educated to ensure patient care was given to the Resident. Post investigation follow up recorded by the Social Services Director recorded Resident #2 was not satisfied with the grievance follow up and declined to sign the grievance. During an observation of Resident #2 on 7/2/24 at 10:30 AM, Resident #2 was in the activity room seated in her wheelchair and well-groomed. Resident #2 said that after she finished the activity, she wanted to talk about a grievance she filed. During an interview on 7/2/24 at 11:00 AM, Resident #2 stated that on 6/7/24 she put on her call light after lunch. Resident #2 further stated, "It must have been before 2 pm, because the Activity Director stopped by my room to see if I was coming to bingo, and bingo started at 2 (PM). I told her I was coming as soon as I got changed." Resident #2 said she told the Activity Director, "I had BM (bowel movement) on me,	F 550	to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of compliance will be July 26, 2024	

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and I was wet." Resident #2 reported that the Activity Director said she would find NA #1 to let her know Resident #2 needed incontinence care, but NA #1 never came back. Resident #2 said she sat there in her room in a soiled/wet brief until the MDS Nurse came "much later" and provided incontinence care. Resident #2 said "It made me very upset and angry, and I told (the MDS Nurse) I was upset that I had to wait for about an hour and a half to get changed, no one should have to wait that long. It just upset me that I can't care for myself, and I have to wait on staff to help me." Resident #2 stated that after the MDS Nurse provided incontinence care, "I felt better." Resident #2 stated that NA #1 came and apologized the next day, and explained why she had to leave and stated, "I told her I understood, but that it upset me to miss bingo and to have to wait that long to be changed."

On 7/1/24 at 12:30 PM the Activity Director stated during an interview, with Resident #2 present that on 6/7/24 the Activity Director observed Resident #2 in her room, seated in her wheelchair, and her call light was on. The Activity Director looked at her watch and said "it's 1:47 PM it's almost time for bingo" and asked Resident #2 if she was coming to bingo. The Activity Director stated that Resident #2 said "yes" that she just turned on her call light a few moments ago to receive incontinence care before going to bingo. The Activity Director said she asked Resident #2 to identify her NA and Resident #2 stated it was NA #1. The Activity Director said she told Resident #2 that she would find NA #1 to let her know that Resident #2 needed incontinence care. The Activity Director said she went to find NA #1 but could not locate her so when the Activity Director saw the Director of Nursing (DON), the Activity

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Director reported to the DON that Resident #2 was in her room with her light on and needed incontinence care. The Activity Director stated that after bingo, which extended until 3:30 PM that day, she went to the MDS Nurse office, who was the Assistant Director of Nursing's (ADON) at the time, and told the MDS Nurse and the DON, who were both in the office, that Resident #2 did not attend bingo. The Activity Director said the MDS Nurse said she would go to Resident #2 to find out what happened. During the interview with the Activity Director, Resident #2 stated that she had to wait for over an hour and a half to receive incontinence care which made her "very upset", so she filed a grievance." Resident #2 stated that she preferred to get up, get dressed and come out of her room for meals and activities, she stated "Me in my room, no, I like to be out."

A phone interview on 7/1/24 at 7:55 PM, NA #1 stated that she no longer worked at the facility but when she did, she worked on the 7 AM to 3 PM shift. NA #1 stated that on 6/7/24 on the 7 AM to 3 PM shift, she provided morning care to Resident #2 around 9:00 or 10:00 AM. NA #1 described that Resident #2 liked to be up/dressed and spent most of her time out of her room. NA #1 said that around 2:40 PM on 6/7/24, Resident #2's call light was on, and the Activity Director came and told NA #1 that Resident #2 needed to be changed. NA #1 said after she saw Resident #2's light on, she went to Resident #2's room and Resident #2 said she needed to be changed. NA #1 said "I told her I had to find the lift" and I would be back. NA #1 said she looked for the mechanical lift but could not find it, asked another NA to help her find it, but did not find it. NA #1 said there were 3 call lights on at the time on the hall which included Resident #2's light, so NA #1

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F 550	Continued From page 5	F 550		

responded to the lights that were on in 2 other resident rooms and when she finished caring for other residents it was 3:07 PM. NA #1 said she looked again for the mechanical lift, but still could not find it, so she had to go. NA #1 said she saw the 3 PM to 11 PM staff at the nurse's station discussing the assignment, so she knew Resident #2 would receive incontinence care. NA#1 said the next day, she went right away to apologize to Resident #2 for not providing incontinence care on 6/7/24 when she told Resident #2 that she would be back. NA #1 said "I know (Resident #2), and I know that she would be upset that I did not come back to give her care, so I went to apologize." When NA #1 apologized, she said Resident #2 responded that she was okay, but that she was upset that she was left wet/soiled so long. Resident #2 said she appreciated the apology, but NA #1 stated, "I knew she would be upset."

An interview on 7/1/24 at 4:35 PM with Nurse #1 revealed she was the assigned Nurse for Resident #2 on 6/7/24 for the 7 AM to 3 PM shift. Nurse #1 stated she recalled the incident with Resident #2. Nurse #1 said in the past Resident #2 expressed that her call light was on for "hours", but her light was on for a few minutes, so Nurse #1 stated she could not be certain if Resident #2's call light was on for over an hour, because she was off the unit for 30 - 35 minutes assisting another nurse, so she did not see it. Nurse #1 said she did not see Resident #2's light on so she did not know that the Resident needed assistance. Nurse #1 stated when she returned to the unit, she overheard the MDS Nurse talking to Med Aide (MA) #1 about how long Resident #2 waited to have her brief changed.

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The MDS Nurse was interviewed on 7/1/24 at 3:00 PM. The MDS Nurse said that at the time of the incident with Resident #2, she was the ADON. She further stated that the Activity Director came to her office on 6/7/24 a little before 3:30 PM while the ADON and DON were there together and reported that Resident #2's call light was on since 1:47 PM and she needed incontinence care. The MDS Nurse said on the way to see Resident #2, she asked MA #1, the NA assigned for Resident #2 on the 3 PM to 11 PM shift, if she had provided incontinence care to Resident #2 since change of shift. The MA #1 said no because she did not know she was assigned to care for Resident #2 on that shift. The MDS Nurse said when she went to see Resident #2, she found Resident #2 in her room, her call light was on, she was seated in her wheelchair, upset and crying. The MDS Nurse said Resident #2 reported she had been in her room waiting for NA #1 to come change her brief so she could go to bingo. The MDS Nurse said, Resident #2 was "so upset and crying, so I just changed her myself." The MDS Nurse said Resident #2's brief was soiled with feces and "moderately" wet with urine. The MDS Nurse said, when she completed the incontinence care for Resident #2, the Resident was still upset and stated she was crying because it was hard waiting on other people to care for her.

During an interview on 7/1/24 at 5:20 PM with MA #1, she stated she was the assigned NA for Resident #2 for the 3 PM - 11 PM shift, but that she did not know that she was the assigned NA for Resident #2 on 6/7/24 for the 3 PM to 11 PM shift until the MDS Nurse asked her sometime after change of shift (3 PM) if she had checked on Resident #2 and provided incontinence care.

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MA #1 said she told the MDS Nurse she was not aware that she was the assigned NA for Resident #2 for the 3 PM to 11 PM shift so she had not checked on Resident #2 yet. MA #1 stated that the MDS Nurse said she would go start the incontinence care to Resident #2 and asked MA #1 to come assist. MA #1 stated she was assisting another resident with care at the time, so when she finished, she went to assist the MDS Nurse with Resident #2's care. MA #1 stated when she arrived to assist with Resident #2's care, it was after 3 PM, her call light was off, and the MDS Nurse had already changed her brief. MA #1 said Resident #2 was upset, and crying and stated that she was crying because she missed bingo and had to wait to be changed.

The Social Services Director stated in an interview on 7/1/24 at 5:41 PM that she received an electronic communication (email) on 6/8/24 from the Activity Director stating that Resident #2 waited on 6/7/24 for incontinence care for over an hour and that a grievance was filed. The Social Services Director said she went to Resident #2 on 6/8/24 and advised her that her concern would be taken care of. Resident #2 expressed that just educating staff was not enough. Resident #2 further said that she wanted to make sure staff provided her care and stated she did not want to wait that long for someone to come answer her light. The Social Services Director said Resident #2 declined to sign the grievance. The Social Services Director said she went back to see Resident #2 a couple days later. Resident #2 said "so far so good" and had no other reports of the same incident occurring. The Social Services Director provided a copy of the email for review.

The DON, MDS Nurse and Activity Director were

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F 550	Continued From page 8 interviewed together on 7/2/24 at 8:59 AM. The DON stated Resident #2 had a history of reporting incidents and when the incident was investigated staff found that the incident did not occur as Resident #2 described. The DON stated that she did recall the Activity Director made her aware on 6/7/24 that she saw the light on for Resident #2 before 2 PM and when she asked Resident #2 what she needed, Resident #2 said she needed incontinence care. The DON said she could not recall the exact time she was made aware of this, but when she was made aware, she delegated to the MDS Nurse to check on Resident #2 which was around 3:30 PM. The DON stated that staff witnessed Resident #2's call light was on before 2 PM because she needed incontinence care and that it upset Resident #2 to wait for over an hour and a half to receive care. The DON stated that NA #1 should have been on the unit and observed if call lights were on, found out what the resident needed and rendered the care. The MDS Nurse said when she went to Resident #2, her call light was on, and the MDS Nurse provided incontinence care to Resident #2. The DON, the MDS Nurse and the Activity Director all confirmed that it was not dignified for a resident to wait in a wet/soiled brief for over an hour and a half for incontinence care.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		7/26/24

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F 584	Continued From page 9 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide a clean homelike environment when they failed to clean tube feeding formula off the feeding tube pole and floor in 1 of 3 resident rooms that had tube	F 584	F584 Intravenous Pole in in Room #201 was cleaned on 7/2/24. Intravenous Poles were audited for cleanliness by the Director of	

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F 584	Continued From page 10 feeding formula (Room 201). The findings included: An observation was made of Room #201 on 07/01/24 at 11:06 AM. There was a feeding tube pump hanging from a pole beside the bed. The pole and floor were observed to have dried light brown substances that appeared to be tube feeding formula. The dried formula covered the pole, the bottle of the pole, and the floor under the pole. An observation was made of Room #201 on 07/01/24 at 12:35 PM. There was a feeding tube pump hanging from a pole beside the bed. The pole and floor were observed to have dried light brown substances that appeared to be tube feeding formula. The dried formula covered the pole, the bottle of the pole, and the floor under the pole. An observation was made of Room #201 on 07/01/24 at 3:10 PM. There was a feeding tube pump hanging from a pole beside the bed. The pole and floor were observed to have dried light brown substances that appeared to be tube feeding formula. The dried formula covered the pole, the bottle of the pole, and the floor under the pole. An observation was made of Room #201 on 07/01/24 at 4:20 PM. There was a feeding tube pump hanging from a pole beside the bed. The pole and floor were observed to have dried light brown substances that appeared to be tube feeding formula. The dried formula covered the pole, the bottle of the pole, and the floor under the pole.	F 584	Housekeeping on 7/2/24. On 7/2/24 to 07/05/24 the Director of Housekeeping initiated staff education to the housekeeping department to clean Intravenous Poles during room cleaning daily or anytime equipment appears dirty. The facility will educate all new employees on hire. As needed training will continue with all staff. The Executive Director or designee will conduct audits related to cleanliness of all medical equipment two times a day 5 days/week for four weeks and then one time a day for four weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Housekeeping will report findings to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of Compliance will be July 26, 2024	

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The Housekeeping Director was interviewed on 07/02/24 at 9:25 AM. The Housekeeping Director was asked to observe Room #201. He stated that the dried light brown substances was dried tube feeding formula. He explained that the housekeepers were to report any dried tube feeding formula to him. He explained that the pole and floor needed to be sprayed with a cleaner and left to soak and then a scraper was required to remove the dried substances. The Housekeeper Director explained that the housekeeping staff did not keep scrapers on their carts that were needed to remove the dried substances so they had been educated to just report the issues to the Director and he would take care of it. The Housekeeping Director confirmed that no one had reported the issue to him and if they had he would have immediately cleaned the pole and floor in Room #201.

Housekeeper #1 was interviewed on 07/02/24 at 9:39 AM who confirmed that she was assigned to clean Room #201 on 07/01/24. She explained that she cleaned Room #201 on 07/01/24 between 8:30 AM and 9:00 AM and the feeding tube pump pole and floor were not dirty. She stated if she had noted it to be dirty, she would have told the Housekeeping Director so he could have sprayed the surface with a cleaner and then used a scraper to get the dried feeding off the pole and floor. Housekeeper #1 stated that dried tube feeding formula does not come off with a rag and has to be soaked and then scraped and she had been educated to report any issues to the Housekeeping Director but stated on 07/01/24 when she cleaned Room #201 it was not dirty. She also added that after she cleaned Room #201 on 07/01/24 between 8:30 AM and 9:00 AM

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F 584	Continued From page 12 she did not return to that room for the remainder of her shift but was supposed to be monitoring the rooms and hallways for spills, trash, or other debris that would need her attention. The Director of Nursing was interviewed on 07/02/24 at 11:46 AM. The Director of Nursing stated that if any member of the staff noted the dried tube feeding formula on the pole and floor then she expected the staff to clean it up or report it to someone who could clean it up. The Administrator was interviewed on 07/02/24 at 4:10 PM who indicated that Room #201 should have been cleaned by a member of the staff at the facility.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews, the facility failed to provide incontinence care when requested to 1 of 2 dependent residents (Resident #2) reviewed for activities of daily living. The findings included: The admission date for Resident #2 to the facility was 11/6/15 with diagnoses that included major depressive disorder, anxiety disorder, overactive bladder, urgency of urination, and urgency incontinence.	F 677	F677 Resident #2 was observed in the dining room on 7/2/2024 well-groomed and dry. Current residents that require staff assistance with toileting needs were audited for timely incontinent care by the Director of Nursing on 7/2/24. On 7/2/24 to 7/5/24 the Director of Nursing provided staff education to the nursing department to cover timeliness of incontinence care in order to attend activities. The facility will educate all new employees on hire. As needed training	7/26/24

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F 677	Continued From page 13 The 8/2/23 annual Minimum Data Set (MDS) assessment recorded it was very important to Resident #2 to attend her favorite activities. The care plan, revised November 2023 indicated Resident #2 had bowel and bladder incontinence and depressive episodes related to immobility, and a neurogenic disorder. The care plan recorded that she may exaggerate events, make false claims and allegations at times. Interventions included encouraging effective communication, checking for incontinence, providing peri-care after each incontinent episode, modifying daily schedule to accommodate community life participation as requested by the resident and encourage participation in activities of choice. Resident #2's 5/1/24 quarterly MDS assessment recorded adequate hearing, adequate vision, with corrective lenses, clear speech, understood, understands, intact cognition, required substantial to maximum toileting hygiene assistance, frequent bladder incontinence, and always incontinent of bowel. A 6/7/24 grievance recorded by the Activity Director indicated that Resident #2 turned on her call light on 6/7/24 at 1:47 PM and requested Nurse Aide (NA) #1 assist her with incontinence care but had to wait. During an observation of Resident #2 on 7/2/24 at 10:30 AM, Resident #2 was observed in the activity room seated in her wheelchair and well-groomed. Resident #2 said that after she finished the activity, she wanted to talk about a grievance she filed. During an interview on 7/2/24	F 677	will continue with all staff. The Director of Nursing or designee will conduct random audits related to incontinent care three times a week for four weeks then weekly for four weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement meeting monthly for three months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of Compliance will be July 26, 2024	

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at 11:00 AM, Resident #2 stated that on 6/7/24 she put on her call light after lunch. Resident #2 further stated, "It must have been before 2 pm, because the Activity Director stopped by my room to see if I was coming to bingo, and bingo started at 2 (PM). I told her I was coming as soon as I got changed." Resident #2 said she told the Activity Director, "I had BM (bowel movement) on me, and I was wet." Resident #2 reported that the Activity Director said she would go and find NA #1 to let her know Resident #2 needed incontinence care, but NA #1 never came back. Resident #2 said she sat there in her room in a soiled/wet brief until the MDS Nurse came "much later" and provided incontinence care. Resident #2 said that the MDS Nurse had provided incontinence care to her before, but stated "That's not her job, so if she has to come and give me care, that's a problem because somebody is not doing their job." Resident #2 said "I told (the MDS Nurse) that I had to wait for about an hour and a half to get changed, no one should have to wait that long." Resident #2 stated that after the MDS Nurse provided incontinence care, "I felt better." Resident #2 stated that NA #1 came and apologized the next day, and explained why she had to leave and stated, "I told her I understood."

On 7/1/24 at 12:30 PM the Activity Director stated during an interview with Resident #2 present that on 6/7/24 the Activity Director rounded before the bingo activity at 2:30 PM to take residents to bingo who wanted to attend. The Activity Director stated that when she arrived at Resident #2's room, the Resident was seated in her wheelchair, her call light was on, the Activity Director looked at her watch, spoke to Resident #2 and said "it's 1:47 PM it's almost time for bingo" and asked Resident #2 if she was coming to bingo. The

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Activity Director stated that Resident #2 said "yes" that she just turned on her call light a few moments ago to receive incontinence care before going to bingo. The Activity Director said she asked Resident #2 to identify her NA and Resident #2 stated it was NA #1. The Activity Director said she told Resident #2 that she would find NA #1 to let her know that Resident #2 needed incontinence care and wanted to go to bingo. The Activity Director said she went to find NA #1 but could not locate her so when the Activity Director saw the Director of Nursing (DON), the Activity Director reported to the DON that Resident #2 wanted to go to bingo, but she was in her room with her light on and needed incontinence care. The Activity Director stated that she went to start the bingo activity because even though the activity was scheduled for 2:30 PM, residents came as early as 2:00 PM for bingo. The Activity Director stated bingo continued longer that day, until 3:30 PM but that Resident #2 did not attend. After bingo was over the Activity Director said she went to the MDS Nurse office, who was the Assistant Director of Nursing's (ADON) at the time, and told the MDS Nurse and the DON, who were in the office together, that Resident #2 did not attend bingo. The Activity Director said the MDS Nurse said she would go to Resident #2 to find out what happened. During the interview with the Activity Director, Resident #2 stated that she did not attend the bingo activity that day because she had to wait for incontinence care. Resident #2 stated that she preferred to get up, get dressed and come out of her room for meals and activities, she stated "Me in my room, no, I like to be out."

A phone interview on 7/1/24 at 7:55 PM, NA #1

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stated that she no longer worked at the facility but used to work at the facility on the 7 AM to 3 PM shift. NA #1 stated that on 6/7/24 7 AM to 3 PM shift, she was the assigned NA for 500 hall and gave care to all her assigned residents. She stated that Resident #2 was on her assignment that day and NA #2 provided morning care to Resident #2 around 9:00 or 10:00 AM. NA #1 described that Resident #2 liked to be up/dressed and spent most of her time out of her room. NA #1 said that around 2:40 PM on 6/7/24, Resident #2's call light was on, and the Activity Director came and told NA #1 that Resident #2 needed to be changed. NA #1 said she told the Activity Director that she would go help Resident #2 but that she had to find the mechanical lift (device used for transfer assistance) first. NA #1 said she did not see Resident #2's call light on before 2:40 PM which may have been because she was in/out of resident rooms providing care on her last round of the shift. NA #1 said after she saw Resident #2's light on, she went to Resident #2's room and Resident #2 said she needed to be changed. NA #1 said "I told her I had to find the lift" and I would be back. NA #1 said she looked for the mechanical lift but could not find it, asked another NA to help her find it, but did not find it. NA #1 said there were 3 call lights on at the time on the 500 hall which included Resident #2's light, so NA #1 responded to the lights that were on in 2 other resident rooms and when she finished caring for other residents it was 3:07 PM. NA #1 said she looked again for the mechanical lift, but still could not find it, so she had to go. NA #1 said she saw the 3 PM to 11 PM staff at the nurse's station discussing the assignment so she knew Resident #2 would receive incontinence care. NA#1 said the next day, she went right away to apologize to Resident #2 for not providing

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incontinence care on 6/7/24 when she told Resident #2 that she would be back. When NA #1 apologized, she said Resident #2 responded that she was ok. Resident #2 said she appreciated the apology.

An interview on 7/1/24 at 4:35 PM with Nurse #1 revealed she was the assigned Nurse for Resident #2 on 6/7/24 for the 7 AM to 3 PM shift. Nurse #1 stated she recalled the incident with Resident #2 because she had to assist a nurse with a resident on another hall. Nurse #1 said she did not see Resident #2's call light on before leaving the unit sometime between 2:00 PM and 2:15 PM and in the past Resident #2 expressed that her call light was on for "hours", but her light was on for a few minutes, so Nurse #1 stated she could not be certain if or how long Resident #2's call light was on, because she did not see it. Nurse #1 said she was off the unit in total for about 30 to 35 minutes. Nurse #1 said she left the unit for 15 or 20 minutes, returned to the unit to get supplies and was off the unit for another 15 to 20 minutes, but that she did not see Resident #2's light on so she did not know that the Resident needed assistance. Nurse #1 stated when she returned to the unit after 30 - 35 minutes, she overheard the MDS Nurse talking to Med Aide (MA) #1 about how long Resident #2 waited to have her brief changed.

The MDS Nurse was interviewed on 7/1/24 at 3:00 PM. The MDS Nurse said that at the time of the incident with Resident #2, she was the ADON. She further stated that the Activity Director came to her office on 6/7/24 a little before 3:30 PM while the ADON and DON were there together and reported that Resident #2's call light was on since 1:47 PM. The MDS Nurse stated the Activity

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Director reported that Resident #2 needed to receive incontinence care before bingo and that Resident #2 did not come to bingo. The MDS Nurse said she went to see Resident #2 and found her in her room, her call light was on, she was seated in her wheelchair. The MDS Nurse said Resident #2 reported she had been in her room waiting for NA #1 to come change her brief so she could go to bingo. The MDS Nurse said "I just changed her myself." The MDS Nurse said Resident #2's brief she was soiled with feces and "moderately" wet with urine, but her clothes and the bed linens were not soiled or wet and her skin was not red or excoriated. The MDS Nurse said she looked for NA #1 on 6/7/24 after she provided incontinence care to Resident #2, but NA #1 had already left the facility, so the MDS Nurse said she spoke to NA #1 the next morning after 7 AM when she arrived at the facility. The MDS Nurse said NA #1 said that she had to leave on 6/7/24 because it was the end of her shift, so she had to go and had already stayed a little over her shift. The MDS Nurse said she re-educated NA #1 that she had to wait for her relief and if a resident needed incontinence care, the NA had to go and provide the care.

During an interview on 7/1/24 at 5:20 PM with MA #1, she stated she worked the 7 AM to 3 PM shift on 6/7/24 in a different hall, but then worked as the NA for Resident #2 for the 3 PM - 11 PM shift. MA #1 stated she did not know that she was the assigned NA for Resident #2 on 6/7/24 for the 3 PM to 11 PM shift until the MDS Nurse asked her sometime after change of shift (3 PM) if she had checked on Resident #2 and provided incontinence care. MA #1 said she told the MDS Nurse she was not aware that she was the assigned NA for Resident #2 for the 3 PM to 11

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PM shift so she had not checked on Resident #2 yet. MA #1 stated that the MDS Nurse said she would go start the incontinence care to Resident #2 and asked MA #1 to come assist. MA #1 stated she was assisting another resident with care at the time, so when she finished, she went to assist the MDS Nurse with Resident #2's care. MA #1 stated when she arrived to assist with Resident #2's care, it was after 3 PM, her call light was off, and the MDS Nurse had already changed her brief.

The DON, MDS Nurse and Activity Director were interviewed on 7/2/24 at 8:59 AM. The DON stated Resident #2 had a history of reporting incidents and when the incident was investigated staff found that the incident did not occur as Resident #2 described. The DON stated that she did recall the Activity Director made her aware on 6/7/24 that she saw the light on for Resident #2 before 2 PM and when she asked Resident #2 what she needed, Resident #2 said she wanted to attend bingo but needed incontinence care first. The DON said she could not recall if she was made aware of this before or after bingo, but when she was made aware, she delegated to the MDS Nurse to check on Resident #2 which was around 3:30 PM. The DON said the MDS Nurse went to Resident #2, her call light was on, and the MDS Nurse provided incontinence care. The DON stated that staff witnessed Resident #2's call light on because she needed incontinence care. The DON, the MDS Nurse and the Activity Director all stated that it was not a reasonable expectation for a resident to wait for over an hour and a half for incontinence care. The DON stated that the NA should have been on the unit and observed if call lights were on, found out what the resident needed and rendered the care.

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F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Medical Director interviews the facility failed to administer tube feedings via a gastrostomy tube as ordered by the physician for 1 of 3 residents reviewed with tube feeding orders (Resident #3). The findings included: Resident #3 was initially admitted to the facility on 08/20/22 and most recently readmitted to the facility on 06/17/24 with diagnoses that included gastrostomy status and sequelae of cerebral infarction.	F 693	F693 Resident #3 feeding tube formula was started on 7/1/24. Resident #3 and a 100% of all residents were audited for timely feeding tube formula initiated per physician orders by the Director of Nursing on 7/1/24. On 7/2/24 to 7/5/24 the Director of Nursing provided staff education to the nursing department to cover timeliness of enteral feeding formula initiation and the	7/26/24

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F 693	Continued From page 21 A physician order dated 05/05/24 read, tube feeding formula continuous at 65 milliliters (ml) per hour via gastrostomy tube. Flush gastrostomy tube with 100 ml of water every four hours. An observation was made of Resident #3 on 07/01/24 at 11:06 AM. Resident #3 was resting in bed with his head of bed elevated. There was a feeding tube pump hanging from a pole beside Resident #3's bed. There was no tube feeding formula hanging from the pole at the time. There was a bottle of tube feeding formula unopened sitting on Resident #3's counter in his room at the end of his bed. An observation was made of Resident #3 on 07/01/24 at 12:35 PM. Resident #3 remained in bed with his head of bed elevated. The feeding tube pump continued to hang from a pole sitting next to Resident #3's bed. There was no feeding tube formula hanging from the pole at the time. The unopened bottle of tube feeding formula remained sitting on Resident #3's counter at the end of his bed. An observation was made of Resident #3 on 07/01/24 at 3:10 PM. Resident #3 remained in bed with his head of bed elevated. The feeding tube pump continued to hang from a pole sitting next to Resident #3's bed. There was no feeding tube formula hanging from the pole at the time. The unopened bottle of tube feeding formula remained sitting on Resident #3's counter at the end of his bed. Nurse #1 was in Resident #3's room at the time and was questioned about Resident #3's tube feeding and replied that Resident #3's tube feeding formula was due to be rehung later in the shift.	F 693	importance of following physician orders. The facility will educate all new employees on hire. As needed training will continue with all staff. The Director of Nursing or designee will conduct audits on 100% of all residents related to enteral feeding care 3x week for 4 weeks and 1x week/for 4 weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement meeting monthly for 2 months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of Compliance will be July 26, 2024	

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Nurse #1 was interviewed on 07/01/24 at 4:07 PM who stated Resident #3's tube feeding was due to be rehung at around 9:00 PM. She stated that she had removed the tube feeding at around 10:00 AM because the bottle that was hanging was empty. When Nurse #1 was questioned again about Resident #3's tube feeding she replied she had three other residents on the unit that required tube feedings and stated, "I could have easily misread it." Nurse #1 obtained her laptop to review Resident #3's orders and stated, "oh he is on continuous, and I will go hang it back up."

An observation of Resident #3 on 07/01/24 at 4:20 PM revealed Resident #3 resting in bed with his head of bed elevated. He was observed to have tube feeding formula infusing via pump at 65 ml per hour.

A follow up interview was conducted with Nurse #1 on 07/01/24 at 5:31 PM, she stated she remembered that Resident #3's gastrostomy tube was leaking earlier in the shift, and she had to replace the tube and she just forgot to restart the feeding.

The Medical Director was interviewed on 07/02/24 at 10:06 AM who stated he had been the Medical Director since June 2024 but had only physically been in the facility for one or two weeks. He stated he was not too familiar with Resident #3 but did have some baseline knowledge of his conditions. He stated that he typically preferred to have residents on intermittent tube feeding but he definitely deferred that ultimate decision to the Registered Dietitian. The Medical Director stated that the tube feeding

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should have immediately been restarted when the tube was replaced, and Resident #3 should not have gone the majority of the day without his ordered tube feeding.

The Director of Nursing was interviewed on 07/02/24 at 11:46 AM who stated she was aware Resident #3's gastrostomy tube was leaking on 07/01/24 and had to be replaced. She stated she was not aware that the nursing staff had not immediately restarted his feeding and he had gone the majority of the day without his ordered feeding. The Director of Nursing stated that Resident #3's tube feeding should have been immediately restarted when his tube was back in place and in working order.

The Registered Dietitian was interviewed via phone on 07/02/24 at 1:16 PM who stated that she was familiar with Resident #3 and had been following him often due to frequent readmissions to the facility. She stated Resident #3 had an order to have nothing by mouth and was on ordered tube feeding through his gastrostomy tube. She stated that he had been on intermittent feedings in the past and continuous feedings in the past. The Dietitian explained that currently Resident #3 was ordered tube feeding formula at 65 ml per hour continuously. Resident #3's weight had been stable over the last few months and for Resident #3 specifically she preferred continuous tube feeding because of tracheostomy status and was less volume at one time and it just made it easier on his body respiratory wise. The Registered Dietitian stated that Resident #3 was 100% feeding tube dependent to meet his nutritional needs and his tube feeding should have been immediately restarted when his tube was reinserted and was functioning properly.

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F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Medical Director interviews the facility failed to change the dressing to a peripherally inserted central catheter (PICC line or an intravenous line) as ordered by the physician for 1 of 1 residents receiving intravenous medication (Resident #3). The finding included: Resident #3 was initially admitted to the facility on 08/20/22 and most recently readmitted to the facility on 06/17/24 with diagnoses that included osteomyelitis of pressure ulcer and an abscess. Review of a hospital discharge summary dated 06/17/24 indicated that Resident #3 had a peripherally inserted central catheter (PICC) line inserted at the hospital on 06/13/24 at 3:46 PM. A physician order dated 06/20/24 read, intravenous (IV) catheter care instructions, inspect and clean right upper extremity and apply a clear dressing every Thursday on day shift. Review of the Medication Administration Record (MAR) dated June 2023 revealed that on June 20, 2024, and June 27, 2024, Nurse #2 initialed the MAR indicating that she had cleaned and inspected Resident #3's right upper extremity and	F 694	F694 Resident #3 Peripherally Inserted Central Catheter dressing was changed on 07/01/24. Resident #3 and 100% residents that require peripherally inserted central catheter were audited for appropriate dressing changes per physician orders. On 07/01/24 to 7/5/24 the Director of Nursing initiated staff education to the nurses to cover timeliness of dressing changes and the importance of following physician orders. The facility will educate all new employees on hire. As needed training will continue with all staff. The Director of Nursing or designee will conduct audit on Resident #3 and 100% of all residents related to peripherally inserted central catheter dressing changes care 3xW/for 4 weeks then weekly for 4 weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social	7/26/24

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F 694	Continued From page 25 applied a clean clear dressing to the PICC line. An observation was made of Resident #3 on 07/01/24 at 11:06 AM. Resident #3 was resting in bed with his head of bed elevated. He was noted to have a PICC line in his right upper extremity that was covered with a clear dressing. The dressing was noted to have rolled up at the edges and had small dirt particles on the sticky side of the dressing that had rolled up. The clear dressing was dated 06/13/24 at 3:59 PM. An observation was made of Resident #3 on 07/01/24 at 12:35 PM. Resident #3 remained in bed with his head of bed elevated. He was noted to have a PICC line in his right upper extremity that was covered with a clear dressing. The dressing was noted to have rolled up at the edges and had small dirt particles on the sticky side of the dressing that had rolled up. The clear dressing was dated 06/13/24 at 3:59 PM. An observation was made of Resident #3 on 07/01/24 at 3:10 PM. Resident #3 remained in bed with his head of bed elevated. He was noted to have a PICC line in his right upper extremity that was covered with a clear dressing. The dressing was noted to have rolled up at the edges and had small dirt particles on the sticky side of the dressing that had rolled up. The clear dressing was dated 06/13/24 at 3:59 PM. An observation was made of Resident #3 along with the Director of Nursing on 07/01/24 at 5:12 PM. The Director of Nursing confirmed that the date on Resident #3's PICC line dressing in his right upper extremity was 06/13/24 at 3:59 PM. She stated it "obviously had not been changed" as documented on the MAR.	F 694	Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement meeting monthly for 2 months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of Compliance will be July 26, 2024	

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F 694	Continued From page 26 Nurse #2 was interviewed via phone on 07/01/24 at 5:21 PM, Nurse #2 stated she worked at the facility at least once a week on Thursdays. She stated she had not changed Resident #3's PICC line dressing in the last month and could not explain why it was documented on the MAR that she had completed the dressing change. Nurse #2 stated that she had checked the dressing, and it was dated for that same day, and she assumed it had already been changed. Nurse #2 added that maybe it was an oversight on her part. The Medical Director was interviewed on 07/02/24 at 10:06 AM who stated PICC line dressings were scheduled to be changed weekly to cut down on the risk of infection and it had been two weeks and needed to be changed. The Medial Director stated he did not want Resident #3 to get septic (severe infection) from a line that has been in place and not been cared for in two weeks. "It is not good practice." The Director of Nursing was interviewed on 07/02/24 at 11:46 AM who stated that Resident #3's PICC line dressing should have changed per the physician order. She added that the facility did not get a lot PICC lines, and this may have been the first or second one that she had seen in the building. However, the Director of Nursing stated the physician order stated the dressing was to be completed weekly and it should have been completed as ordered.	F 694		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		7/26/24

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F 695	Continued From page 27 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 ensure that a tracheostomy (surgical airway in the front of the neck) dependent residents' oxygen was delivered at the prescribed rate, failed to clean the oxygen concentrator and oxygen concentrator filter for 1 of 3 residents reviewed for respiratory services (Resident #3). The findings included: Resident #3 was initially admitted to the facility on 08/20/22 and most recently readmitted to the facility on 06/17/24 with diagnoses that included chronic respiratory failure status post tracheostomy. A quarterly Minimum Data Set dated 03/16/24 indicated Resident #3 was severely cognitively impaired for daily decision making, had no shortness of breath, received oxygen therapy, and tracheostomy care during the assessment reference period. A physician order dated 06/28/24 read 4 liters of oxygen via tracheostomy collar continuous. Further review of physician orders revealed no order for cleaning of oxygen filters or oxygen concentrator.	F 695	F695 Resident #3 was placed on respiratory support/oxygen therapy as ordered via tracheostomy on 07/01/24. Resident #3 and 100% of all residents that require respiratory support/oxygen therapy were audited for appropriate oxygen settings per physician orders on 07/01/24. The facility will conduct audits for any new admission with continuous oxygen. On 07/01/24 to 07/05/24 the Director of Nursing initiated staff education to the nurses to cover respiratory support/oxygen therapy and the importance of following physician orders to deliver the correct oxygen flow rate. The facility will educate all new employees on hire. As needed training will continue with all staff. The Director of Nursing or designee will conduct audits for Resident #3 and 100% of resident that receive continuous oxygen, related to respiratory support/oxygen therapy care for	

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F 695	Continued From page 28 An observation was made of Resident #3 on 07/01/24 at 11:06 AM. Resident #3 was resting in bed with his head of bed elevated. Resident #3 was noted to have an oxygen concentrator sitting next to his bed that was connected to his tracheostomy collar, the concentrator was set to deliver 3.5 liters of oxygen. The oxygen concentrator was dirty with dried brown substances that resembled tube feeding formula, other white stains and debris, and the filter on the right side of the concentrator was white with dust particles. Resident #3 was noted to be in a room by himself and appeared in no acute distress. An observation was made of Resident #3 on 07/01/24 at 12:35 PM. Resident #3 was resting in bed with his head of bed elevated. Resident #3 was noted to have an oxygen concentrator sitting next to his bed that was connected to his tracheostomy collar, the concentrator was set to deliver 3.5 liters of oxygen. The oxygen concentrator was dirty with dried brown substances that resembled tube feeding formula, other white stains and debris, and the filter on the right side of the concentrator was white with dust particles. Resident #3 was noted to be in a room by himself and appeared in no acute distress. An observation was made of Resident #3 on 07/01/24 at 3:10 PM. Resident #3 remained in bed with his head of bed elevated. Resident #3 was noted to have an oxygen concentrator sitting next to his bed that was connected to his tracheostomy collar, the concentrator was set to deliver 3.5 liters of oxygen. The oxygen concentrator was dirty with dried brown substances that resembled tube feeding formula, other white stains and debris, and the filter on the right side of the concentrator was white with dust	F 695	appropriate oxygen settings for 3xweek/for four weeks then weekly for four weeks. The Quality Assurance Performance improvement committee members consist of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement meeting monthly for two months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of Compliance will be July 26, 2024	

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particles. Resident #3 was noted to be in a room by himself and appeared to be in no acute distress.

Nurse #1 was interviewed on 07/01/24 at 4:07 PM who confirmed that she was caring for Resident #3. She stated that the night shift staff were to change out the oxygen tubing and ensure the concentrator was working properly. She stated that she did check the oxygen concentrator setting at least once or twice a shift. Nurse #1 stated Resident #3 was on 4 liters of oxygen via his tracheostomy collar. Nurse #1 added that she did not know who cleaned the oxygen concentrators or filters, she only knew that as the nurse on the hallway that task was not assigned to her. Nurse #1 was asked to observe the oxygen concentrator and confirmed that the setting was on 3.5 liters. She stated she had checked it earlier on the shift and it was correct. Nurse #1 was observed to place the oxygen concentrator back on 4 liters and proceeded to check Resident #3's oxygen saturation level which was 99%. She added that Resident #3 was not able to change the oxygen concentrator and he had no roommate, so she was not sure what happened. Nurse #1 acknowledged the oxygen concentrator filter and stated that it was very dusty and needed to be cleaned as did the concentrator.

The Housekeeping Director was interviewed on 07/02/24 at 9:25 AM. He stated that both the nursing department and the housekeeping department were responsible for cleaning the oxygen concentrator and filters in the rooms. The Housekeeping Director observed the oxygen concentrator at Resident #3's bedside and stated that the dirt and debris on the oxygen

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concentrator could be sprayed with cleaner and removed by wiping them down. He stated the housekeeping staff should be looking at them daily and if they saw tube feeding formula on the equipment, they were to let the Housekeeping Director know so he could properly clean the concentrator. He stated that no one had reported issues to him regarding Resident #3's concentrator. The Housekeeping Director was observed to spray the oxygen concentrator with a cleaning product and then wipe it down with a rag. The dirt and debris were easily removed.

Housekeeper #1 was interviewed on 07/02/24 at 9:39 AM who confirmed that she was assigned to clean Resident #3's room on 07/01/24. She explained that she cleaned Resident #3's room on 07/01/24 between 8:30 AM and 9:00 AM and his oxygen concentrator was not dirty and had not returned to his room for the remainder of her shift. She stated if she had noted it to be dirty, she would have told the Housekeeping Director or the Nursing staffing because she was not supposed "to bother the oxygen concentrator." Housekeeper #1 stated she was able to do a quick wipe down of the concentrator if it needed it but if it needed to be scrubbed or deep cleaned that would be up to the nursing department. Houskeeper #1 again stated that the oxygen concentrator was not dirty when she cleaned Resident #3's room on 07/01/24.

The Director of Nursing was interviewed on 07/02/24 at 11:46 AM who stated that the night shift staff were tasked with changing the tubing and other needed equipment. The Director of Nursing stated she did not know who was responsible for cleaning the oxygen concentrator and/or filters. She added that there was no

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F 695	Continued From page 31 schedule of cleaning the filters that she was aware of. However, the Director of Nursing stated if the staff went into a room, and something needed to be cleaned then they should clean it or tell someone that could clean it. She added Nurse #1 was responsible for checking at least once a shift that Resident #3 was on the correct dose of oxygen via his tracheostomy collar. The DON completed the interview by stating Resident #3 "can absolutely not change his oxygen settings and he is the only resident in that room."	F 695		
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 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-	F 842		7/26/24

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(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.

§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

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F 842	Continued From page 33 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 to maintain a complete an accurate medical record when Nurse #2 documented that she changed a peripherally inserted central catheter line (intravenous line) dressing on two occasions when the dressing was not changed as ordered for 1 of 1 residents reviewed who required intravenous medications (Resident #3). The findings included: A physician order dated 06/20/24 read, intravenous (IV) catheter care instructions, inspect and clean right upper extremity and apply a clear dressing every Thursday on day shift. Review of the Medication Administration Record (MAR) dated June 2023 revealed that on June 20, 2024, and June 27, 2024, Nurse #2 initialed the MAR indicating that she had cleaned and inspected Resident #3's right upper extremity and applied a clean clear dressing to the PICC line. An observation was made of Resident #3 on 07/01/24 at 11:06 AM. Resident #3 was resting in bed with his head of bed elevated. He was noted to have a PICC line in his right upper extremity that was covered with a clear dressing. The dressing was noted to have rolled up at the edges and had small dirt particles on the sticky side of the dressing that had rolled up. The clear dressing was dated 06/13/24 at 3:59 PM. An observation was made of Resident #3 on 07/01/24 at 3:10 PM. Resident #3 remained in bed with his head of bed elevated. He was noted	F 842	F842 Resident #3 Peripherally Inserted Central Catheter dressing was changed and documented on 07/01/24. Resident #3 and 100% of all residents charts was audited for appropriate and correct nursing documentation for dressing changes for Peripherally Inserted Central catheter. The facility will conduct audits for any new admission with PICC line care to ensure correct documentation. On 07/01/24 to 07/05/24 the Director of Nursing initiated nursing staff education to cover the importance of appropriate and correct nursing documentation for 100% of residents including Resident #3. The facility will educate all new employees on hire. As needed training will continue with all staff. The Director of Nursing or designee will conduct audits on Resident #3 and any new resident related to appropriate and correct nursing documentation related to peripherally inserted central catheter dressing changes and documentation care 3x W/ for 4 weeks weekly for 4 weeks. The Quality Assurance Performance improvement committee members consist	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

(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 34 to have a PICC line in his right upper extremity that was covered with a clear dressing. The dressing was noted to have rolled up at the edges and had small dirt particles on the sticky side of the dressing that had rolled up. The clear dressing was dated 06/13/24 at 3:59 PM. An observation was made of Resident #3 along with the Director of Nursing on 07/01/24 at 5:12 PM. The Director of Nursing confirmed that the date on Resident #3's PICC line dressing in his right upper extremity was 06/13/24 at 3:59 PM. She stated it "obviously had not been changed" as documented on the MAR. Nurse #2 was interviewed via phone on 07/01/24 at 5:21 PM, Nurse #2 stated she worked at the facility at least once a week on Thursdays. She stated she had not changed Resident #3's PICC line dressing in the last month and could not explain why it was documented on the MAR that she had completed the dressing change. Nurse #2 stated that she had checked the dressing, and it was dated for that same day, and she assumed it had already been changed. Nurse #2 added that maybe it was an oversight on her part. The Director of Nursing was interviewed on 07/02/24 at 11:46 AM who stated that Resident #3's PICC line dressing should have changed per the physician order and if Nurse #2 did not complete the dressing she should not have documented that she did. She added she was disappointed that Nurse #2 documented that she did something when clearly, she did not.	F 842	of but not limited to Administrator, Director of Nursing, Unit Manager, Social Services, Medical director, maintenance Director, Housekeeping Services, dietary Manager, and Minimum data Set Nurse and minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement meeting monthly for 2 months. The findings of the monitoring tool will be discussed/reviewed in Quality Assurance Performance Improvement meeting. Date of Compliance will be July 26, 2024	