STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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E 000	Initial Comments An unannounced onsite recertification and complaint survey was conducted on 2/10/25 through 2/13/25. Additional information was obtained offsite from 02/14/25 through 02/20/25. Therefore, the exit date was changed to 02/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #U3E311.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint survey was conducted on 2/10/25 through 2/13/25. Additional information was obtained offsite from 02/14/25 through 02/20/25. Therefore, the exit date was changed to 02/20/25. Event ID #U3E311. The following intakes were investigated: NC00226813, NC00226293, NC00226144, NC00226187, NC00225289, NC00225087, NC00224666, NC00224628, NC00221989, NC00222063, NC00219923, NC00219579, NC00217894, NC00216182, NC00215083, NC00213740, and NC00210887. 7 of 39 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 553		3/20/25

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

Electronically Signed 03/17/2025

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F 553	Continued From page 1 (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, Resident Representative, and Department of Social Services (DSS) Guardian interviews, the facility failed to ensure residents were given the right to participate in the revision of their person-centered care plans for 2 of 2 residents reviewed for care planning (Resident #12 and Resident #14). The findings included: 1. Resident #12 was admitted on 04/04/2024 with diagnoses that included rheumatoid arthritis, frequent falls, depression, degenerative joint	F 553	1. Resident #12 and resident #14 received a care plan invitation on 3/18/25 for a scheduled care plan meeting held on 03/20/25. 2. A quality review was completed by the Administrator to determine if residents/responsible parties have been invited to attend a care plan meeting, if the meeting was documented within the last quarter. If any residents/responsible parties are not invited to attend and there is no documentation of the care plan meeting, a care plan meeting will be	

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F 553	Continued From page 2 disease, and chronic joint pain. The quarterly Minimum Data Set (MDS) assessments dated 10/31/2024 and 01/24/2025 specified Resident #12 was cognitively intact. Review of Resident #12's electronic medical record revealed no evidence that she was invited to attend care plan meetings to discuss and provide input regarding her plan of care. An interview with Resident #12 on 02/10/2025 at 2:42 PM revealed that she did not recall being invited to a care plan conference or having her goals/progress discussed with her. Resident #12 indicated she would have liked to have talked about her progress and would have attended a care conference. An interview on 02/12/2025 at 11:06 AM with the Social Services Director indicated the care plan conference notification process began when Social Services received the MDS schedule from the MDS Coordinator. Social Services then verbally invited the Resident Representative via phone. Social Services provided the Resident with the Care Plan Conference Notification Letter. Social Services documented the care plan conference discussion and attendance in a social services progress note in the electronic medical record. The Social Services Director indicated she had invited Resident #12's Representative by telephone call and provided Resident #12 with the Care Plan Conference Notification Letter when care plan conferences were scheduled. Resident 12's last documented care plan conference listed on the care conference record was 08/07/2024. A review of the care conference record revealed	F 553	scheduled. This audit was completed by 3/17/25. 3. The Administrator educated the Social Services Director by 3/17/25 on the importance of inviting the resident/responsible to attend scheduled care plan meetings and to document the invitation and the meeting in the resident□s electronic record. Newly hired Social Services Director educated during orientation. 4. The Administrator or their designee will conduct a weekly audit to ensure that those residents who are scheduled for a care plan meeting have received an invitation to attend and the care plan meeting has been documented in the resident□s electronic record. This audit will be conducted weekly x 12 weeks and then monthly x 2 months. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical	

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F 553	Continued From page 3 no care conference documentation or invitation for the care plan conference scheduled following the 10/31/2024 and 01/24/2025 MDS assessments. An interview via telephone call on 02/13/2025 at 11:25 AM with Resident #12's Resident Representative (RR) revealed the RR did not recall participating in a care plan conference or ever discussing Resident #12's goals or progress with the facility. An interview on 02/14/2025 at 11:27 AM with the Administrator indicated that the care plan conference process was a Social Services responsibility. Social Services should contact the Resident and/or Resident Representative and arrange the date and time of the conference and then advise the team. The Administrator explained that the Social Worker would document the care plan conference and attendance in the resident's electronic medical record. 2. Resident #14 was admitted on 04/05/2016 with diagnoses that included peripheral vascular disease, paroxysmal atrial fibrillation, hypertensive heart disease without heart failure, Stage 3 chronic kidney disease, moderate dementia without behavioral disturbance, and depression. Resident #14's care plan revised on 11/25/2024 specified that Resident #14 had impaired cognitive function/dementia. A care plan intervention stated staff would communicate with the Resident/Resident's Representative regarding the Resident's capabilities and needs. The quarterly Minimum Data Set (MDS)	F 553	Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

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F 553	Continued From page 4	F 553		

assessment dated 12/03/2024 indicated that Resident #14 was cognitively intact.

An interview with Resident #14 on 02/11/2025 at 9:12 AM revealed Resident #14 did not recall being invited to a care plan conference or a care plan conference being held.

An interview on 02/12/2025 at 11:06 AM with the Social Services Director indicated the care plan conference notification process began when Social Services received the MDS schedule from the MDS Coordinator. Social Services then verbally invited the Resident's Guardian via phone. Social Services provided the Resident with the Care Plan Conference Notification Letter. Social Services documented the care plan conference discussion and attendance in a social services progress note in the electronic medical record. The Social Services Director indicated that she had invited Resident #14's Guardian and provided the Care Plan Conference Notification Letter to Resident #14. Resident #14's last care plan conference documented on the conference record was 06/20/2024 and Resident 14's signature was on the care conference record as having attended. There was no Social Service progress note that documented the 06/20/2024 care plan conference in the electronic medical record.

A review of the care conference record revealed no care conference documentation or invitation for the care plan conference scheduled following the 09/01/2024 and 12/03/2024 quarterly MDS assessments.

In a telephone interview on 02/13/2025 at 1:38 PM with Resident #14's DSS Guardian, she

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F 553	Continued From page 5 disclosed she had not received a care plan conference invitation for Resident #14 for some time including December 2024. An interview on 02/14/2025 at 11:27 AM with the Administrator indicated that the care plan conference process was a Social Services responsibility. Social Services should contact the Resident and/or Resident Representative and arrange the date and time of the conference and then advise the team. The Administrator explained that the Social Worker would document the care plan conference and attendance in the resident's electronic medical record.	F 553		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		3/20/25

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F 583	Continued From page 6 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interview, the facility failed to provide personal privacy during incontinent care when the Nurse Aide exited the room during care and left the door to Resident #48's room open while the resident was unclothed and uncovered resulting in the resident being visible from the hallway while he was exposed. This deficient practice affected 1 of 1 resident reviewed for privacy (Resident 48). The findings included: Resident # 48 was admitted to the facility on 11/28/24. The quarterly Minimum Data Set (MDS) assessment dated 12/5/24 revealed that Resident #48 was cognitively intact, frequently incontinent, and dependent on assistance for activities of daily living (ADL). An observation of incontinent care provided by Nurse Aide (NA) #1 for Resident #48 was conducted on 2/12/25 at 6:22 AM. NA #1 placed	F 583	1. Resident #48 was not affected related to this citation to provide privacy during incontinent care when NA #1 exited the room during care and left the door open. NA #1 was educated by the Director of Nursing on providing privacy during incontinent care on 03/17/2025. 2. On 03/11/2025, the Director of Nursing and or Nursing Supervisor, through personal observation of residents, ensured residents are provided privacy during incontinent care ensuring residents door was closed and resident not exposed. ADHOC Quality Assurance Performance Improvement Committee was held by 3/17/25 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Clinical Services educated nursing staff on personal privacy related to ensuring privacy is provided by closing of door and privacy curtain when care is being provided by 3/17/25. Nursing	

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F 583	Continued From page 7	F 583		

gloves on her hands outside the room. She was observed to have washcloths and linen supplies in the room with running water in the bathroom sink. She wiped Resident #48 with the washcloth and placed a clean pad and draw sheet underneath Resident #48. NA #1 then placed Resident #48 on his back and gave him a urinal. Resident #48 was without clothing or covering when NA #1 opened the door to leave the room to get gloves. NA #1 did not cover Resident #48 or offer Resident #48 to be covered. NA #1 left the door open with Resident #48 exposed to the hallway. When NA #1 returned, she closed the door, then continued to assist Resident #48 in dressing for the day.

An interview with Resident #48 was conducted on 2/12/25 at 6:40 AM. Resident #48 stated NA #1 would leave his room while his entire body was exposed. Resident #48 stated he was "tired" of NA #1 coming in his room "like she was angry" and leaving him exposed to the hallway for others to see him. Resident #48 verbalized he was unable to cover himself due to weakness after he had a stroke.

An interview with NA #1 on 2/12/25 at 6:50 AM stated her normal process was to have all supplies in the room when providing incontinent care. If she needed to leave the room she would cover the resident, close the curtain and the door. NA #1 stated she had not realized she left the door open leaving Resident #48 exposed when she left the resident's room. The NA stated she should have shut the door since the resident was exposed.

On 2/12/25 at 6:45 AM an interview with Nurse #4 stated the normal process when providing

staff will complete the education prior to working the next scheduled shift. Newly hired nursing staff will be educated upon new hire during orientation.

4. The Director of Clinical Services or designee will conduct 5 random quality reviews weekly by observation of staff provided care to ensure privacy by closing the door and privacy curtain. This quality review will be conducted weekly x 12 weeks and then monthly x 2months. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff

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F 583	Continued From page 8 incontinent care was to take the linen bin and cart to the room to have all supplies and place dirty linen in bags. If staff needed to leave the room, privacy was provided with the curtain or covering the resident. The Director of Nursing (DON) interview was conducted on 02/13/25 at 1:16 PM. The DON stated that all supplies for incontinent care should be in all residents' rooms. The DON stated that when staff needed to leave the resident's room for any reason, staff should cover the resident for privacy and drop bed down in the lowest position for safety. The DON stated no staff member should leave a resident exposed. An Administrator interview was conducted on 02/14/25 at 11:02 AM. The Administrator stated staff should maintain privacy during incontinence care and keep doors closed and the curtain pulled to maintain privacy.	F 583		
F 600 SS=D	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	F 600		3/20/25

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F 600	Continued From page 9 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #20 hit Resident #7 on the back of his head and neck with a metal cane after Resident #7 entered back into their shared room to retrieve a personal item. Resident #7 had a raised red area on the back of his neck. This affected 1 of 3 residents reviewed for abuse (Resident #7). The findings included: Resident #7 was admitted to the facility on 1/27/22 with diagnoses that included type 2 diabetes and essential primary hypertension. A review of Resident #7's care plan updated on 12/23/24 read he had a psychosocial wellbeing problem potentially related to disease process. The goal read Resident #7 will demonstrate adjustment to nursing home placement through review date. The interventions included allowing time to answer questions and verbalize feelings perceptions, and fears and initiate referrals as needed. Review of the annual Minimum Data Set (MDS) dated 12/2/24 revealed that Resident #7 was cognitively intact and had no behaviors. Resident #20 was admitted to the facility on 6/24/21 with diagnosis that included end stage renal disease, essential primary hypertension, and unspecified intellectual disabilities.	F 600	1. Resident #20 was removed from the facility and sent to the emergency department for evaluation on 02/02/2025. Resident #7 was evaluated for red area on the back of his neck with no negative findings. 2. The Administrator, Director of Nursing and or Nursing Supervisor interviewed alert and oriented residents with no negative findings by 03/19/25. The Director of Nursing, Nursing Supervisor and or licensed nurses completed skin assessments on non-alert and oriented residents by 03/19/25. An ADHOC Quality Assurance Performance Improvement Committee was held by 3/17/25 to formulate and approve a plan of correction for the deficient practice. 3. Administrator and DON educated all staff on the organization□s abuse and neglect policy by 3/17/25. A resident town hall will be held to educate residents on the abuse and neglect policy. Newly hired staff will be educated upon hire during education. 4. The DON, ADON, or designee will conduct 5 random weekly skin sweeps/observation quality reviews on non-alert and oriented assigned residents, 5 alert and oriented residents to be interviewed in regards to abuse or higher	

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F 600	Continued From page 10 The quarterly MDS dated 11/19/24 indicated Resident #20 was moderately cognitively impaired, had no physical or verbal behavioral symptoms directed towards others, but did reject evaluation or care on a daily basis. A review of Resident #20's care plan last reviewed on 1/15/25 read he had potential to be physically aggressive when parting with possessions and trash, due to his belief he needed to save them. The goal read Resident #20 would not harm self or others, he would seek staff when agitation occurred and verbalize understanding of need to control physically aggressive behavior. Interventions included analyzing times of day, places, circumstances, triggers, and de-escalate behavior and document, assessing for contributing sensory deficits, and intervening before agitation escalated, guiding away from sources of distress, and engaging calmly in conversation. An initial allegation report dated 2/2/25 read Resident #7 was hit by Resident #20 with a cane. Residents were immediately separated, and Resident #7 had a bump on his head and a reddened area on his neck. Both residents remained separated. The report was signed by the Administrator on 2/2/25. A progress note for Resident #4 written by Nurse #5 dated 2/2/25 at 6:37 PM indicated Resident #7 was hit twice on the head with a cane by Resident #20 at 4:00 PM. Resident #7 was assisted to safety and assessed. The note further revealed a small red spot at the back of his head. The note read Resident #7 denied pain or discomfort and neurological checks were completed and Resident #7 was noted stable within his clinical	F 600	3x weekly x 12 weeks then monthly for 2 months to ensure residents are free from abuse/neglect. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

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F 600	Continued From page 11	F 600		

baseline. He refused transport for evaluation at the emergency room.

Nurse #5 was interviewed on 2/13/25 at 11:39 AM. She stated Resident #20 hit Resident #7 with his cane from behind when Resident #7 went back into his room to retrieve a personal item. She stated Resident #7 originally left the room because Resident #20 had been upset. Nursing Aide #8 separated them. She removed the cane and other metal objects from the room. Nurse #5 revealed Resident #7 had some redness on the back of his head but there was no swelling. She explained that she completed neurological checks as he refused transport to the hospital for evaluation, and he was fine. Nurse #5 stated Resident #7 wanted to be left alone and did not want to file charges with the police.

A review of NA #5 witness statement was conducted. She heard Resident #7 crying out and saying he was being assaulted. She opened the door and found Resident #20 beating Resident #7 with his four-pronged cane while holding on to his chair. She stated Resident #20 was the only person fighting. She separated them.

Multiple attempts were made to interview Nursing Aide (NA) #5 but were unsuccessful.

An interview with Resident #7 on 2/13/25 at 12:34 PM revealed he was near the bathroom when he was hit on the head by Resident #20 with an object. He stated that he was moved to a different room after the incident. Resident #7 stated he couldn't recall exact details of the incident but stated he was not hurt, and he tried to get along with everyone in the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 600	Continued From page 12	F 600		

The Social Worker (SW) was interviewed on 2/13/25 at 10:30 AM. She revealed Resident #20 did not like people near his belongings and it caused him to have aggressive behaviors. He had a roommate for a long time, and they were very compatible. When the roommate was discharged, she stated Resident #7 was a good match as Resident #7 had a lot of belongings. The SW explained staff was optimistic but after a couple of days together, Resident #20 became upset with Resident #7 in his space. The SW stated Resident #7 was moved to a private room for a day or two and wanted to move back. She stated when the incident occurred, Resident #7 removed himself from the room after Resident #20 became upset and he went back in to get his glasses. The SW explained Resident #7 took accountability for going back into the room when she discussed the incident with him the following day. She stated he was moved to the 400 hall and she set up counseling services for him.

The DON was interviewed on 2/13/25 at 12:52 PM. She revealed Resident #7 went into the room to retrieve his glasses and then Resident #20 struck him with the cane. Resident #7 called out and staff separated them. The DON stated Resident #7 did not want to press charges and Resident #20 was sent to the hospital for evaluation.

The Administrator was interviewed on 2/13/25 at 1:09 PM. He explained Resident #20 was aggressive when others were near his belongings, but he had not exhibited this level of aggressive behavior before this incident and wasn't generally a mean person. The Administrator stated Resident #20 was sent out

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F 600	Continued From page 13 for evaluation to the hospital after the incident.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to maintain documented evidence of a thorough investigation of an allegation of misappropriation of medication for 2 of 4 residents (Residents #278 & #279) reviewed for misappropriation of property. Findings included: a. Resident #278 was admitted to the facility on 9/10/15 with diagnoses that included hypertension and non-Alzheimer's dementia. b. Resident #279 was admitted to the facility on	F 610	1.Resident #278 and Resident #279 The Administrator and DON will conduct an audit of all narcotic sheets to ensure no misappropriation. This audit will be completed by 3/18/25.Resident #278 and #279 are no longer residents at the facility. 2.All residents have the potential to be affected by this deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 3/17/25 to formulate and approve a plan of correction for the deficient practice.	3/20/25

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F 610	Continued From page 14 7/24/23 and discharged home on 7/31/24. Her diagnoses included Diabetes Mellitus. The Initial Allegation Report dated 2/20/24 revealed the facility became aware of an allegation of drug diversion of resident drugs on 2/20/24 at 8:30 AM. Resident #278 was noted to be the affected resident. The Facility Investigation Report dated 2/22/24 read in part on the summary of the investigation for alleged narcotics missing for Resident #278. The Director of Nursing (DON) was notified that the narcotic medication was unable to be located in the narcotic lock box for Resident #278. At approximately 8:05 AM on 2/20/24 Nurse #6 was interviewed, urine drug screen tested negative, and suspended until further investigation of the missing narcotic. The DON called Nurse #7 to request she come into the facility. Nurse #7 stated she was out of town and would report to the facility the next day when she was scheduled to work. Nurse #7 did not come or call out for work on her scheduled shift. She did not answer her phone when the DON called her. There was no documentation related to Resident #279. The Facility Investigation Report dated 2/22/24 continued to read the facility put the following interventions in place to ensure ongoing safety of residents. - Audit of Narcotics for residents from 2/17 through 2/22, no resident's affected. - Staff interviewed. - Review of Narcotic records of residents receiving narcotics, no resident's affected. - Quality Assurance monitoring was completed for staff, no staff witnessed any other staff member appropriating facility property.	F 610	3.The Administrator and DON will provide education to all staff on the organizations abuse policy and procedure to include misappropriation of resident property. All reported alleged allegations will be reviewed within 2 hours, 24 hours, and finally at the 5 day follow up. This audit will be conducted weekly x 12 weeks and then monthly x2 months.The Administrator will report the results of the audits to the QAPI committee to ensure compliance is achieved and maintained, monthly for 3 months and then quarterly for 2 quarters. Newly hired staff will be educated in orientation. 4.The Regional Vice President of Operations will educate the Administrator and DON of the organization s policy on the investigation process for alleged allegations. The Administrator will report the results of the audits to the QAPI committee to ensure compliance is achieved and maintained, monthly for 3 months and then quarterly for 2 quarters. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be	

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	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 610	Continued From page 15 - Education for licensed nurses started on 2/22/24 provided for Misappropriation of Resident's Property. Education will be ongoing upon hire, annually, and as needed to ensure proper protocol for Narcotics. An interview on 2/12/25 at 8:55 AM with Nurse #8 revealed that on 2/20/24 around 8:00 AM during morning shift narcotic medication count with Nurse #6, she had noted that Resident #278's discontinued narcotic medication had not been returned to the pharmacy. She also noted that Resident #279 had a new narcotic medication card and her previous card, which should have had pills on it, was missing. She stated she declined to take control of the narcotic keys from Nurse #6 and notified the DON of the medication abnormalities. An interview on 2/12/25 at 1:39 PM with the former Administrator revealed that the former DON completed the drug diversion investigation, and he had no direct knowledge of the investigation. An interview on 2/12/25 at 3:23 PM with the former DON revealed she was employed at the facility in February 2024 and completed this missing narcotic medication investigation. She stated she remembered the drug diversion and had left the completed investigation folder in the DON office. She stated the missing narcotics for Resident #278 and Resident #279 were not located. The former DON stated she did not know why only one resident, Resident #278, was identified on the facility reported investigation report faxed to the state agency or why Resident #279 was not listed on the report.	F 610	modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

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F 610	Continued From page 16 An interview on 2/13/25 at 12:26 PM with the former Administrator and the Vice President of Clinical Operations revealed they had looked through the drug diversion investigation folder from the former DON's office and were unable to find the narcotic count sheets, substance inventory count sheets, staff interviews or audit sheets. An additional interview on 2/13/25 at 1:07 PM with the former DON revealed that all the investigation information was in the folder, and she had no further information. An additional interview on 2/13/25 at 1:37 PM with the former Administrator and the Vice President of Clinical Operations revealed they had been unable to locate any further documentation. Review of the facility investigation report documentation revealed that there were no documents for Resident #279 missing narcotics or that the BON was notified. The investigation folder revealed no shift control substance inventory count sheets for February 2024, no narcotic sign out sheets for Resident #278 or #279, no staff interviews, and no narcotic medication audit sheets. An interview on 2/13/25 at 1:40 PM with the Administrator revealed that he was not employed at the facility during this missing narcotic investigation and had no additional information.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 17	F 623		

resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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F 623	Continued From page 18	F 623		

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon

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F 623	Continued From page 19 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Regional Ombudsman interviews, the facility failed to provide a complete written notice of transfer/discharge that included the Nursing Home Hearing Request form to the Resident and Resident Representative for 1 of 3 residents (Resident #20) reviewed for facility-initiated discharge. The findings included: Resident #20 was admitted to the facility on 6/24/21. The quarterly Minimum Data Set assessment dated 11/19/24 indicated Resident #20 was moderately cognitively impaired. A review of the record revealed Resident #20 had a Resident Representative (RR) listed as an emergency contact. A review of a nurse's progress note written by the Director of Nursing (DON) dated 2/2/25 revealed	F 623	1. A complete 2-page copy of the Nursing Home Hearing Request form was sent to Resident #20□s responsible party, the hospital case manager and the Regional Ombudsman by the Administrator on 02/03/25. 2. A quality review was conducted on all residents that were discharged or transferred out of the facility within the last quarter to ensure the complete transfer/discharge notice was sent to the resident, responsible party, and Regional Ombudsman office. The Administrator conducted the audit by 3/17/25. 3. On 3/17/25 the Regional Vice president of Operations educated the Administrator on completing and submitting all required pages of the transfer/discharge notice to the resident, responsible party, and the Regional Ombudsman upon transfer to the hospital and for immediate discharge. Newly	

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F 623	Continued From page 20 Resident #20 was sent to the emergency room for a psychological evaluation and treatment due to behaviors. The facility did not readmit Resident #20. An interview with the DON on 2/13/25 at 12:52 PM revealed she called Resident #20's RR on 2/3/25 and informed him that Resident #20 was admitted to the hospital and the facility would not accept him back due to his behaviors. She stated the Administrator consulted with the Regional Ombudsman and a discharge notice was issued to the hospital Social Worker for Resident #20. She stated she was unsure if Resident #20 or his RR received the notice sent to the hospital Social Worker. She stated she was not aware of any discussion related to issuing both pages of the transfer/discharge notice. A review of Resident #20's record revealed a notice of transfer/discharge form was completed by the Administrator on 2/3/25 but did not include the second page entitled Nursing Home Hearing Request form. A telephone interview was conducted with the Regional Ombudsman on 2/13/25 at 8:05 AM. She stated she had a telephone discussion with the Administrator and the DON regarding Resident #20's discharge from the facility. The facility emailed a copy of the transfer/discharge notice and upon receiving it, she informed the Administrator over email the form was not complete as it did not contain the second page of the notice for Resident #20 to appeal the discharge. An interview was conducted with the	F 623	hired Administrators will be educated during orientation. 4. The Administrator or designee will conduct a weekly audit to ensure any residents that are transferred/discharged from the facility have received a notice of transfer/discharge form with documentation in the electronic record as well as their responsible party and Regional Ombudsman. This audit will be conducted weekly x 12 weeks and then monthly x2 months. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

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F 623	Continued From page 21 Administrator on 2/13/25 at 1:09 PM. The Administrator stated he did not attach the second page of the transfer/discharge notice on 2/3/25. He stated when he pulled up the form on his computer, it only included one page. He was not aware there was a second page for a Hearing Request until the Regional Ombudsman alerted him to it.	F 623		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident	F 626		3/20/25

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F 626	Continued From page 22 returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, and Hospital Case Manager and staff interviews, the facility failed to allow a resident to return to the facility after being sent to the hospital for a medical evaluation using the residents' behaviors prior to discharge as a basis for their decision for 1 of 3 residents reviewed for transfer and discharge (Resident #20). The findings included: Resident #20 was admitted to the facility on 6/24/21. Diagnosis included end stage renal disease, essential primary hypertension, and unspecified intellectual disabilities. A review of a nurse's progress notes dated 2/2/25 revealed Resident #20 struck another resident with a cane, attempted to hit staff with objects and barricaded himself in his room. Resident #20 was sent to the emergency room for a psychological evaluation. A review of a second nurse's progress note dated 2/2/25 revealed Resident #20 was sent to the emergency room for a psychological evaluation and treatment due to behaviors. An interview with the Director of Nursing on	F 626	1. Resident #20 was discharged to the hospital on 02/02/2025 for the safety and health of other individuals/ residents residing in the facility due to physical aggressive behaviors towards another resident. Resident #20 remains in the hospital due to his behaviors being an endangerment to other individuals/ residents in the facility and or other facilities making it difficult to place resident from the hospital. Resident #20 will discharge to a sister facility nearby when services needed for Resident #20 is set up from the hospital. The Administrator issued an immediate discharge notice for reason the safety of individuals in the facility is endangered due to clinical or behavioral status of the resident and the health of individuals in the facility would otherwise be endangered. 2. A quality review was completed by the Administrator by 3/17/25 of residents sent to the hospital for evaluation/treatment and not permitted back to the facility. No residents were identified in this quality review.	

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F 626	Continued From page 23 2/13/25 at 12:52 PM revealed she called Resident #20's Resident Representative (RR) on 2/3/25 and informed him that Resident #20 was admitted to the hospital and the facility would not accept him back due to his behaviors. She stated she called Resident #20's RR on 2/3/25 and explained that the facility was not an appropriate placement for him due to his aggressive behaviors. The DON stated a transfer/discharge notice was issued on 2/3/25 and a copy was given to the hospital social worker. She explained the hospital social worker initially pressured them to accept Resident #20 back to the facility. She stated Resident #20's family came and retrieved his belongings. Multiple attempts were made during the survey to interview the hospital social worker and were unsuccessful. An interview with the Administrator on 2/13/25 at 1:09 PM revealed he was aware Resident #20 was sent to the hospital after an incident where Resident #20 struck another resident with a metal cane. He stated Resident #20 would not return to the facility due to his behaviors and his diagnosis of an intellectual and developmental disability (IDD). The Administrator stated his other residents in the facility would not be safe if Resident #20 returned to the facility due to his aggressive behavior he exhibited when others were near his belongings. He stated the hospital social worker pushed to have Resident #20 return to the facility, but he stated she understood after a notice of transfer/discharge was issued. He stated the hospital would have to find placement for him. He indicated the hospital social worker would have a hard time placing Resident #20 in another facility.	F 626	3. The Vice President of Regional Operations will educate the Administrator and Director of Clinical Services on the organization□s policy on permitting residents to return to the facility by 03/17/25 4. The Administrator will audit the acute return to hospital residents daily in clinical morning meeting for 12 weeks to ensure residents are permitted to return to the facility when deemed appropriate. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 626	Continued From page 24 The Administrator was informed by the survey team on 2/14/25 at 11:08 AM that there was an expectation for the facility to allow Resident #20 to return. A telephone interview with the hospital case manager occurred on 2/19/25 at 9:31 AM. She stated she was familiar with Resident #20 as he was inpatient at the hospital as of 2/19/25. She explained the case management team was actively looking for placement in another facility for him. The Hospital Case Manager stated she had a discussion with the Administrator on the afternoon of 2/14/25. She indicated the facility would not accept Resident #20 back to the facility due to his ongoing verbal and physical aggression towards staff and other residents. She stated Resident #20 had been cleared for medical discharge for many days and was currently waiting on placement in a facility.	F 626		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of prognosis for a resident receiving Hospice services and discharge location for 2 of 27 reviewed for accuracy of assessment (Resident #9 and Resident #73). The findings included:	F 641	1. Resident #9□s Minimum Data Set□s (MDS) was modified by the traveler MDS Coordinator in the areas of Hospice prognosis to accurately reflect the resident□s status dated 01/15/25. Resident #73□s Minimum Data Set□s (MDS) was modified by the traveler MDS Coordinator in the areas of discharge location to accurately reflect resident□s	3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 25 1. Resident #9 was admitted to the facility on 06/02/2023 with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and adult failure to thrive. A Hospice contract dated 01/14/2025 certified that Resident #9 was admitted under the care and services of Hospice for end of life. Further review of the Hospice admission documentation for Resident #9 indicated that a certification of Resident #9's prognosis of 6 months or less was received on 01/14/2025 at 9:24 AM. A significant change MDS assessment dated 01/15/2025 had been completed. Resident #9 was cognitively intact and received Hospice services. Resident #9's prognosis of 6 months or less was coded no. A telephone interview on 02/13/2025 at 3:28 PM with the previous MDS Coordinator revealed that she coded no for the significant change MDS assessment dated 01/15/2025 as she had no certification of the prognosis of 6 months or less. She explained she had coded yes to Section O-Special Treatments/ Services as she had been advised that Hospice services had been initiated for Resident #9. An interview on 02/14/25 at 11:27 AM with the Administrator indicated that the MDS assessment should be accurate. 2. Resident #73 was admitted to the facility on 11/07/2024. His diagnoses included muscle weaknessand adult failure to thrive.	F 641	discharge dated 11/27/24. By 3/17/25, the Administrator, MDS Coordinator or MDS Regional Coordinator will complete a quality review of the discharge MDS assessment for each resident that discharged from the facility within the last quarter. 2. A quality review was completed on Hospice residents MDS in the areas of prognosis to validate the most recent MDS assessment have been coded to accurately reflect the status of the resident by the traveler MDS coordinator by 03/17/25. A 30 day lookback quality review was completed on residents MDS in the areas of discharge location to validate the most recent MDS assessment have been coded to accurately reflect the discharge location of the resident by the traveler MDS coordinator by 03/17/25. The Administrator or MDS Regional Coordinator provided the MDS coordinator with education on properly coding the discharge location of any discharged residents. 3. The Administrator and or designee will complete a weekly audit to ensure that each resident discharged from the facility has the appropriate discharge location coded in the discharge MDS. This quality review will be completed weekly x 12 weeks and then monthly x 2 months. The Administrator and or designee will complete a weekly audit to ensure that Hospice residents prognosis is coded accurately on the MDS.. This quality	

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F 641	Continued From page 26 Resident #73 had a discharge home with spouse care plan in place initiated on 11/07/2024. Interventions included discuss with the resident/resident's representative/caregivers the prognosis for independent or assisted living and identify, discuss and address limitations, risks, benefits and needs for maximum independence. The discharge Minimum Data Set (MDS) dated 11/27/2024 revealed Resident #73's discharge location was an acute hospital. Resident #73 was moderately cognitively impaired and had active discharge planning in process. Review of Resident #73's electronic medical record on 2/12/2025 revealed documentation that Resident #73 discharged home on 11/27/2024 with family. An interview was completed with the Social Worker on 2/12/2025 at 9:47 AM who stated Resident #73 was admitted to the facility for short term rehabilitation with discharge plans to return home with family. The Social Worker explained she arranged home health services, and no durable medical equipment was indicated. The Social Worker was not aware of Resident #73 discharging to the hospital from the facility. The Social Worker expressed Resident #73 discharged from the facility on 11/27/2024 to home with family. An interview was completed on 2/12/2025 at 10:04 AM with the traveling MDS Nurse. The traveling MDS Nurse stated she would have reviewed the resident's progress notes and would have been involved with discharge planning-inclusive of discharge location. The traveling MDS Nurse was not certain why the discharge	F 641	review will be completed weekly x 12 weeks and then monthly x 2 months. 4. The results of the Quality Improvement Committee Monitoring will be reported to the Quality assurance Performance Improvement Committee by the Administrator and or the Director of Clinical Services to ensure compliance is achieved and maintained. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

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F 641	Continued From page 27 location was not coded accurately. The traveling MDS Nurse further stated the discharge location should be accurately reflected in the MDS for discharge location. An interview with the Administrator was completed on 2/12/2025 at 11:00 AM. The Administrator voiced the MDS should be coded accurately to reflect the actual discharge location of the resident. A telephone interview was completed on 2/13/2025 at 3:28 PM with the previous MDS Nurse. She explained she coded the discharge location in error for Resident #73.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations,and family, staff, and Nurse Practitioner interviews, the facility failed to implement fall prevention interventions consistent with resident's care plan (Resident #5 and Resident #6) and failed to provide a safe transfer using a mechanical lift for Resident #36. This deficient practice occurred for 3 of 6 residents (Resident #5, Resident #6 and Resident #36) reviewed for accidents.	F 689	1. Resident #5 fall mat was placed by the bed as documented in care plan by the Director of Nursing on 02/20/25. Resident #6 fall mat was placed by the bed as documented in care plan by the Director of Nursing on 02/20/25. Resident #36 was not affected by the citation. NA #8 was educated on 02/09/24 when the incident occurred by the Director of Nursing at that time.	3/20/25

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F 689	Continued From page 28 The findings included: Resident # 6 was admitted to the facility on 1/24/25. Diagnosis included cerebral infarction with right side weakness, muscle weakness, unspecified dementia, and unsteady on feet. The quarterly Minimum Data Set (MDS) assessment dated 2/1/25 revealed that Resident #6 was severely cognitively impaired, required partial to moderate assistance for transfers, walking not attempted due to safety, no falls prior to admission and one fall since admission with no injury. The incident report dated 1/28/25 revealed that an aide and nurse observed resident sitting on buttocks on the floor in front of wheelchair at nurse's station. Resident #6's predisposing physiological factors were confused, gait imbalanced, and impaired memory. No injuries were observed, Resident #6 denied pain and was not sent to the hospital. Fall was reported to Physician and family member. The incident report dated 2/5/25 revealed the nurse was in the middle of her medication pass when an aide notified her Resident #6 was on the floor. Resident #6's was ambulating without assistance. Resident #6's predisposing physiological factors were confused, gait imbalanced, and impaired memory. No injuries were observed, Resident #6 denied pain and was not sent to the hospital. Fall was reported to Physician and family member. Resident #6's care plan updated 02/05/25 revealed a focus on resident was a fall risk related to weakness. Goal to minimize the risk of	F 689	2. A quality review of all falls within the last quarter was completed to ensure residents that have fall mat interventions have a fall mat placed in their room by 3/17/25. s. Re-education to nursing staff started on 2/9/24 by the Director of Nursing/ Unit Managers when the incident occurred regarding proper transfers with special focus on use of Mechanical list and how to verify the appropriate transfer status for individual resident. When the incident occurred, The DCS/Nurse Manager/ Designee observe a transfer for nursing employees to ensure that appropriate transfer technique is being used demonstrated during resident transfers by 02/14/24. 3. The Director of Clinical Services will educate all nursing staff on providing fall mats to residents after fall mats have been identified as a fall intervention by 03/17/25. The Director of Clinical Services will also provide education to all nursing staff on the organization□s policy of operation of a mechanical lift by 03/17/25. Nursing staff will complete the education prior to working the next scheduled shift. Newly hired nursing staff will be educated upon new hire during orientation. 4. The Director of Clinical Services will audit all falls interventions to ensure if a fall mat is an intervention that fall mat has been placed in the resident□s room for x1 weekly for 12 weeks then monthly x 2 months. The Director of Clinical services	

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F 689	Continued From page 29 falls. Interventions included anticipating resident's needs (1/27/25), maintaining call bell in in resident's reach (1/27/25), Dycem (sticky nonslip material) to wheelchair cushion (1/28/25), fall mat x1 while resident was in bed (2/5/25), and low bed position (2/5/25). An observation completed on 2/10/ 25 at 1:07 PM revealed Resident #6 was asleep in the bed which was in the lowest position and a fall mat was not observed in the room. An observation completed on 2/11/25 at 2:00 PM revealed Resident #6 was sleeping in the bed which was in the lowest position and a fall mat was not observed in the room. An in person interview with Resident #6's family member on 2/10/25 at 12:13 PM revealed Resident #6 fell twice in her room while in the facility. The family member verbalized she was notified of both falls and that Resident #6 was not injured. The family member stated the facility informed her that a fall mat would be placed in Resident #6's room after Resident #6's first fall on 01/28/25 and she had never observed a fall mat in Resident #6's room. Nurse #4 stated during an interview on 2/12/25 at 6:20 AM, Resident #6 would try to get out of bed without assistance during the 11:00 PM to 7:00 AM shift; however, Resident #6 has not had a fall while she was assigned to Resident #6. Nurse #4 verbalized she would observe Resident #6 often for fall risk and if she observed Resident #6 getting out of bed without assistance, Nurse #4 would assist Resident #6 into a wheelchair and have Resident #6 sit by Nurse #4 at the nurse's station. Nurse #4 stated she had never seen a	F 689	will observe 3 mechanical lift transfers, 1x weekly x 12 weeks then 3 mechanical lift transfers monthly x 2 months to ensure staff are following the safety policy and procedure. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

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F 689	Continued From page 30	F 689		

fall mat in Resident #6's room and did not recall if a fall mat was included in Resident #6's care plan.

An interview with Nurse #3 on 2/13/25 at 10:20 AM stated she had been assigned to Resident #6 and was not aware Resident #6 did not have a fall mat in her room or required a fall mat. Nurse #3 verbalized that she did not know who would place the fall mat if ordered and did not know where fall mats were stored.

Nurse Aide (NA) #4 was interviewed on 2/13/25 at 12:46 PM and stated that NA #4 had not worked with Resident #6 before being assigned to Resident #6 on 2/13/25 and had not observed a fall mat in the room. NA #4 also verbalized if she needed a fall mat she would ask the assigned nurse for assistance.

An interview was conducted with the Director of Nursing (DON) on 02/13/25 at 1:02 PM. The DON stated when a resident had a fall it was discussed during the morning meeting with representatives from each facility discipline. The DON verbalized fall interventions were discussed and decided as a group, then the Minimum Data Set (MDS) Nurse would add the intervention to the resident's care plan. The representative from maintenance or housekeeping would retrieve the fall mat and place the fall mat in the resident's room. The DON stated that the nurse would assess if the fall mat was in place and the intervention was completed. DON verbalized the fall mat should have been in the room.

An interview with the Administrator on 02/14/25 10:52 AM stated falls would be communicated in the facility team morning meeting to address

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F 689	Continued From page 31	F 689		

prevention for future falls. The Administrator verbalized fall mats were placed by nursing, maintenance, or unit manager who all have access to storage. Fall mats were cleaned in a resident's room and removed once the resident was discharged from the facility. The Administrator stated that the method of fall prevention was communicated with family and then should be validated by nursing that fall mat was in place.

2. Resident #5 was admitted to the facility on 12/30/22 with diagnoses that included cerebrovascular accident and Diabetes Mellitus.

Review of Physician's orders for Resident #5 revealed an order dated 4/23/24 for a fall mat to the left side of bed every shift.

Review of Resident #5's care plan last revised 12/22/24 revealed a focus that read in part that the resident has potential for falls related to impaired mobility, incontinence, and unawareness of safety needs. An intervention read for a floor mat at bedside.

Review of Resident #5's fall report dated 12/22/24 at 5:00 PM revealed the resident was found on the floor laying on the fall mat with no visible injuries noted.

The quarterly Minimum Data Set dated 1/10/25 revealed Resident #5 had moderately impaired cognition, was dependent on staff for most activities of daily living and had no refusals of care. She was coded for one fall with no injury during the 7 days look back period.

An interview on 2/10/25 at 6:09 PM with Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 32	F 689		

#5's responsible party revealed that the resident had a history of falls and used to have a fall mat, but it had not been in the resident's room lately. She was unable to say when she last saw the fall mat but thought it should be by her bed when she was in the bed.

An observation on 2/11/25 at 12:45 PM revealed Resident #5 in bed with no fall mat by her bed. There was no fall mat observed in the room or adjoining bathroom.

An observation on 2/11/25 at 3:20 PM revealed Resident #5 in bed with no fall mat by her bed. There was no fall mat observed in the room or adjoining bathroom.

An observation on 2/12/25 at 8:10 AM revealed Resident #5 in bed with no fall mat by her bed. There was no fall mat observed in the room or adjoining bathroom.

An observation and interview on 2/12/25 at 8:11 AM with the Director of Nursing (DON) in Resident #5's room revealed the resident was in the bed and no fall mat was by her bed. There was no fall mat observed in the room or adjoining bathroom. The DON stated the resident was supposed to have a fall mat and she did not know why there was no fall mat by Resident #5's bed or in the room.

An interview on 2/12/25 at 8:19 AM with Nursing Assistant (NA) #5 revealed she was assigned to provide care for Resident #5 that day and provided care for her regularly. She stated she was not aware Resident #5 was supposed to have a fall mat and had not seen one in her room.

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F 689	Continued From page 33	F 689		

An interview on 2/12/25 at 11:24 AM with Nurse #5 revealed she was assigned to Resident #5 that day and had been assigned to her in the past. She stated she was not aware the resident was care planned for a fall mat. She stated she had observed a fall mat in the resident's room a week or so ago when she assisted housekeeping and doesn't know what happened to it.

An interview on 2/12/25 at 1:49 PM with the Administrator revealed that Resident #5 should have a fall mat beside her bed. He stated he thought that when the room was deep cleaned by housekeeping, they removed the fall mat to clean it and had not returned it to the room. He stated this was an oversight on the facility's part.

An interview on 2/12/25 at 1:58 PM with the Housekeeping District Manager revealed that fall mats or equipment were not removed from the room during deep cleaning. He stated they were wiped and left in the room.

3. Resident #36 was admitted to the facility on 7/29/21 with diagnoses including a chronic neurologic disorder and hypertension.

The care plan dated revised 04/13/22 and revealed Resident #36 had a problem area related to activities of daily living self-care performance deficit due to impaired mobility and one intervention was to use a mechanical lift and two-person assistance for transfers (added 08/09/21).

The quarterly Minimum Data Set (MDS) dated 02/06/24 indicated Resident #43 was cognitively intact.

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	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 689	Continued From page 34	F 689		

An interview conducted with Resident #36 on 02/11/25 at 9:10 AM revealed that Resident #36 had no recollection of the fall that occurred on 02/08/24.

A review of the facility incident report dated 2/8/24 at 7:02 PM written by the previous Director of Nursing (DON) revealed Resident #36 was being transferred with the mechanical lift when Nurse Aide (NA) #8 attempted to lift Resident #36 on mechanical lift and Resident #36's weight shifted causing the lift to tilt. The report indicated Resident #36 slid off the bed to the floor. Assessment was completed and no injuries were noted, and Resident #36 was able to move all extremities without difficulty and denied hitting her head.

A review of a nursing progress note written by the former DON on 2/8/24 revealed she spoke to the Nurse Practitioner (NP) regarding Resident #36's fall as well as Resident #36's Resident Representative (RR). She noted no injuries were present.

A telephone interview with Resident #36's RR on 2/12/25 at 10:39 AM revealed NA #8 was bringing Resident #36 back to her room from a shower. When she was transferring her into the bed, she proceeded to move Resident #36 to her bed and the lift tilted over and she fell on the other side of the bed. The RR stated she asked to have mobile x-rays completed and she stated the results were negative for any fractures. The RR indicated she was not present during the incident but was notified after it occurred.

An interview with NA #8 on 2/12/25 at 5:13 PM revealed she worked with Resident #36 on 2/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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F 689	Continued From page 35	F 689		

and was bringing her back to her room after a shower. When she transferred her using the mechanical lift, the lift tilted forward, and Resident #36 ended up on the other side of the bed, in between the wall and the bed. She stated Resident #36 remained in the lift pad which was near the floor. She called for help and NA #7 assisted her with the mechanical lift. NA #8 stated she believed the base of the lift was caught on a part of the bed and Resident #36's weight shifted causing the lift to lean forward. NA #8 did not indicate a reason why she transferred Resident #36 alone but acknowledged that she was aware all mechanical lifts required two-person assistance.

An interview with NA #7 occurred on 2/12/25 at 5:25 PM. She stated she happened to be walking down the hallway on 02/08/24 when NA#8 called for help. She stated she went in to assist her and saw Resident #36 on the other side of the bed between the bed and the wall seated in the mechanical lift pad which was near the floor. She explained she helped lower Resident #36 to the floor with the mechanical lift for Unit Manager #1 to assess her. NA #7 stated that after Resident #36 was assessed by Unit Manger #1, she and NA #8 used the mechanical lift to put Resident #36 back into the bed.

A telephone interview with the former DON on 2/12/25 at 3:39 PM revealed NA #8 was using the mechanical lift to place Resident #36 in bed. The bed was not against the wall and the lift leaned forward and the Resident #36 fell in the lift pad towards the floor. She stated NA #8 did not have an additional NA to assist her with the mechanical lift transfer as their staff has been instructed to do. The former DON stated Resident #36's skin

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F 689	Continued From page 36	F 689		

assessment was clear upon assessment with no injuries noted and she was noted to have normal range of motion. The former DON confirmed that she responded to the room at the time of the incident and assisted Unit Manager #1 with assessing Resident #36, who was noted to have no injury.

Multiple attempts were made to contact Unit Manager #1 during the survey and were unsuccessful.

An interview with the NP on 2/14/25 at 9:08 AM revealed she was unsure if she took the call on 2/8/24 when the incident occurred, but stated their office was notified of the incident.

An interview with the Director of Maintenance on 2/12/26 at 3:20 PM revealed he inspected the mechanical lifts after the accident on 02/08/24 and took one lift out of circulation because the manual lever was not operating correctly to open the legs on the base of the lift. The Director of Maintenance could not confirm that the lift that did not work properly was the lift used on Resident #36 on 2/08/24 but he did take it out of service.

An interview was conducted with the Former Administrator on 2/13/25 at 1:18 PM revealed he was made aware of the mechanical lift incident with Resident #36 when the lift titled forward and placed Resident #36 on the other side of the bed, between the wall and her bed. He noted the staff assisted her by lowering her down with the mechanical lift to the ground for assessment. He stated NA #8 should not have used the mechanical lift by herself and the accident was caused by operator error.

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	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 698	Continued From page 37	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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, and Dialysis Nurse, staff and physician interviews, the facility failed to maintain ongoing communication with the dialysis center and failed to consistently document assessments of the dialysis access site post dialysis including monitoring for bleeding, pain, and condition of skin for 1 of 1 resident reviewed for dialysis (Resident #53). The findings included: Resident #53 was admitted to the facility on 11/12/24. Diagnoses included end stage renal disease (ESRD) and dependent on dialysis. A physician's order written on 11/12/24 revealed Resident #53 to receive dialysis on Monday, Wednesday, and Friday; check dialysis access site each shift for bruit (sound) and thrill (pulsation); assess site (left lower forearm) for bruising/symptoms of infection. The quarterly Minimum Data Set (MDS) assessment dated 11/19/24 revealed Resident #53 was moderately cognitively impaired and received dialysis services. Resident #53's active care plan dated 11/29/24	F 698	1. Resident #53 received the dialysis pre and post dialysis communication for completed by licensed nurse to take with him to dialysis on 3/17/25. Resident #53 is transported to and from dialysis from outside transportation and or facility van. 2. The Director of Clinical Services, Assistant Director of Clinical Services and Unit Managers conducted a quality review for the past 30 days to ensure Dialysis communication form pre and post dialysis section is completed by the licensed nurse and the dialysis order section in electronic medical record (EMR) is completed and signed for without any omissions. This quality review was completed by 3/17/25. 3. The Director of Clinical Services, Assistant Director of Clinical Services, and Unit Managers educated all nursing staff on Dialysis policy and procedure, how to complete the dialysis communication form pre and post dialysis, and how to sign for the dialysis order section in the EMR. New hired staff will be educated in orientation.	3/20/25

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	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 698	Continued From page 38 revealed a plan of care for requiring hemodialysis with a goal the resident would have no signs or symptoms of complications from dialysis. Interventions included: check and change dressing daily at access site, document assessment. Monitor/document/report as needed any signs or symptoms of infection to access site such as redness, swelling, warmth or drainage. Record review revealed the hemodialysis communication form for the post dialysis section was not completed for January (2, 4, 6, 8, 13, 15, 17, 20, 24. 29) of 2025. The electronic health record (EHR) dialysis section was not completed for January (6,8, 13, 15,17, 20,24) of 2025. EHR documentation in the dialysis section that described the site location, appearance and assessment for signs and symptoms of infection was not documented by staff for the month of January 2025. An interview was conducted with Nurse #1 on 2/11/25 at 1:05 PM. Nurse #1 stated when Resident #53 returned from dialysis the staff would assess dialysis access site, pain, vital signs and provided medications that were scheduled. Nurse #1 stated staff would communicate assessment and dialysis information to the physician if needed. Nurse #1 discussed staff should document in the dialysis communication book and electronic health record (EHR). Nurse #1 was observed accessing the dialysis documentation in the EHR to show the completed access assessment documentation completed by the day and night staff for the past week February (4-11) of 2025. The EHR revealed that staff assessed the bruit and thrill of the dialysis access site but there was no documentation for the appearance of dialysis	F 698	4. The Assistant Director of Clinical Services and Unit managers will audit Dialysis communication books and dialysis EHR orders daily in clinical for 12 weeks to ensure dialysis documentation is being completed and documented per policy and procedure. The Administrator will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 698	Continued From page 39	F 698		

access site for signs and symptoms of infection.

A telephone interview with the Dialysis Nurse on 02/12/25 at 2:09 PM stated the dialysis center did not always receive the communication book/form from the facility for Resident #53. All the dialysis nurses and technicians were trained to complete the clinic's section on the dialysis communication form. If there was a change in condition or updated order, the Dialysis Nurse stated the clinic would call or fax the facility staff. The Dialysis Nurse stated Resident #53 had a bandage on the dialysis access site and that the access site should be assessed by facility staff after removing the bandage from Resident #53. The Dialysis Nurse stated leaving the dressing on for an extended period caused indents to the arterial venous fistula (the access used for dialysis treatment) and made it difficult to access the fistula to receive dialysis.

An interview completed on 02/12/25 at 3:31 PM with Nurse #2 stated when a resident returned from dialysis, nurses completed the communication form and assessed the dialysis access site and documented their assessment on the form. Nurse #2 stated the care plan has a place in the EHR to document dialysis access site assessment. She stated both forms and the EHR should be completed by the nurse post dialysis.

The interview with the Physician on 02/13/25 at 10:15 AM stated he did not recall reviewing the dialysis book or any other form of dialysis communication. He discussed depending on the nursing staff to notify him of any changes or new orders from dialysis. The Physician explained the nursing staff should follow the standing orders for communicating with dialysis and assessing

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F 698	Continued From page 40 residents pre and post dialysis services. An interview was conducted with the Director of Nursing (DON) on 02/13/25 at 1:10 PM. The DON stated there was a dialysis book for each dialysis resident. She explained the book went to and from dialysis with the resident. The facility nursing staff were responsible for completing the pre-dialysis section (top part of the dialysis communication form) prior to the resident leaving for dialysis services and the post-dialysis section (bottom part of the dialysis communication form) when the resident returned to the facility. The dialysis clinic completed the dialysis section (middle section of the dialysis communication form.) In the EHR, there was another area for nursing staff to document the monitoring of the access site. Both areas of documentation should be completed by nursing staff when the resident returned from dialysis. An interview with the Administrator on 02/14/25 at 10:46 AM stated a dialysis communication book was sent with the resident to allow the facility and dialysis clinic to communicate regarding the resident. The Administrator stated he was not familiar with the sections on the dialysis communication form, but nursing staff should complete the form with the required information.	F 698		
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	F 880		3/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 41 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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 §483.71 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	F 880		

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F 880	Continued From page 42 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to disinfect a resident's dedicated glucometer according to manufacturer's guidelines for cleaning and disinfecting glucometers for 1 of 2 residents observed for infection control practices (Resident #69). The findings included: Review of the glucometers manual revealed only wipes with environmental protection agency (EPA) registration number listed in the tables could be used to clean the glucometers. Resident glucometers should be cleaned with EPA regulatory wipe once for cleaning followed by one wipe for disinfecting. Then allow the glucometer to dry for 3 minutes.	F 880	1. Resident #69 was affected related to this citation. Nurse #3 was re-educated by the Director of Nursing on disinfect residents dedicated glucometer according to manufactures guidelines for cleaning and disinfecting glucometers by 03/17/25. 2. The Director of Clinical Services, Assistant Director of Clinical Services and Unit Managers conducted an audit of all residents assigned glucometers and nursing carts for the appropriate disinfecting wipes as per policy and procedure by 03/17/25. All resident assigned glucometers cleaned and disinfected as per policy and procedure 3. The Director of Clinical Services,	

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	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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F 880	Continued From page 43 The facility's infection control policy on disinfecting glucometer (Not Dated) included: 1. Wear appropriate protective gear such as disposable gloves. 2. Open the cap of disinfectant container and pull out 1 towelette to clean the meter and close the cap. 3. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette. Carefully wipe around the test strip port. 4. Properly dispose of the used towelette. 5. Open the towelette container and pull out 1 towelette to disinfect the meter and close the lid. 6. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette. Carefully wipe around the test strip port. 7. Properly dispose of the used towelette. 8. Treated surface must remain wet for recommended contact time. Please refer to the Assure Prism Multi BGMS User Manual for hepatitis B contact times. For all other contact times, refer to the wipe manufacturers' instructions. DO NOT WRAP THE METER IN A WIPE. Once contact time is complete, wipe meter dry. 9. After disinfection, the user's gloves should be removed and thrown away. Wash hands before proceeding to the next patient. During a medication pass/continuous observation on 02/13/25 at 4:25 PM, Nurse #3 was observed taking Resident #69's glucometer out of medication cart and obtained a blood sample from Resident #69 to monitor blood sugar level with Resident #69's personal use glucometer. When Nurse #3 completed monitoring Resident	F 880	Assistant Director of Clinical Services, and Unit Managers will educate all nursing staff on cleaning and disinfecting glucometers as per policy and procedure by 03/17/25. Newly hired staff will be educated in orientation. 4. Regional Director of Clinical Services will educate Director of Clinical Services on glucometer cleaning and disinfection policy and procedure. The Assistant Director of Clinical Services and Unit managers will observe nurses during med pass for glucometer cleaning and disinfecting 3 x a week for 12 weeks to ensure glucometers are being cleaned and disinfected per policy and procedure. The Director of Clinical Services will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by Administrator. Quality monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of by not limited to the Administrator, Director of Clinical Services, Unit Managers, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment and at least one direct care staff. 5. 03/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

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WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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F 880	Continued From page 44	F 880		

#69's blood sugar, she placed the glucometer on the medication cart, removed gloves from her hand, retrieved an alcohol 4 x 4-inch pad, and began to clean the glucometer with the one alcohol pad. Nurse #3 placed the glucometer in Resident #69's storage case immediately after cleaning with alcohol pad and placed glucometer back in the medication cart. Nurse #3 stated she cleaned all the residents' individual glucometers with the white top wipes (EPA approved wipes) in the morning and used the alcohol pads for the rest of the day because it was "just the way" she cleaned glucometers. Nurse #3 verbalized she completed the facilities online computer-based glucometer training when she was hired two months ago.

During the interview with the Director of Nursing (DON) on 02/13/25 at 04:35 PM, the DON stated staff should use white top wipes with bleach and wait for a wet (3-minute dry time) time after the use of the glucometer and should have gloves on when cleaning the glucometer. The DON verbalized that all nursing staff have a supply of white top wipes or could request more white top wipes if needed. DON stated there was never a reason to use any other form of disinfecting and cleaning of the glucometer other than using the white top wipes.

In an interview with the Administrator on 2/14/25 at 10:42 AM, he stated that all staff received training on operating and cleaning glucometers based on the manufacturer's booklet. The Administrator verbalized glucometer training took place at the time of hire and then validated by return demonstration by the staff member. A copy of the skills validation was kept by the Director of Nursing per the Administrator. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

(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 45 Administrator stated the type of wipes needed to clean the glucometer was included in staff training.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345473	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	**6001 WILORA LAKE ROAD CHARLOTTE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 638	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days following the Assessment Reference Date (ARD, last day of the assessment period) for 1 of 27 residents reviewed for MDS assessment (Resident #12). The findings included: Resident #12 was admitted 04/04/2024. A record review on 02/14/2025 at 9:57 AM showed the status of Resident #12's 01/24/2025 quarterly MDS as "In Progress." A telephone interview on 02/14/2025 at 10:37 AM with the previous MDS Coordinator revealed that she initiated the MDS for 01/24/2025 and had 14 days to complete and transmit the assessment to CMS (Centers for Medicare and Medicaid Services). The previous MDS Coordinator was not certain why the assessment was not completed but indicated she did not return to the facility to work after 02/9/2025. An interview on 02/14/2025 at 10:41 AM with the Traveling MDS Coordinator revealed this was her fifth day at the facility and she was in process of completing and transmitting the past due MDS assessments. She was not certain why the previous MDS Coordinator did not complete the assessment within the designated timeframe. An interview on 02/14/2025 at 11:27 AM with the Administrator indicated the MDS should be completed on time.
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345473	A. BUILDING: _____ B. WING _____	2/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1

(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to transmit to the Centers for Medicare and Medicaid Services (CMS) database a discharge Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for community discharge (Resident #65).

The findings included:

Resident #65 was admitted to the facility on 8/6/2024.

Facility documentation indicated Resident #65 had been discharged home on 1/27/2025.

On 2/12/2025, Resident #65's discharge MDS assessment dated 1/27/2025 was observed as "In Progress", appeared to be completed, but had not been transmitted to the CMS database as required.

An interview was completed with the traveling MDS Nurse on 2/12/2025 at 10:04 AM who stated when MDS assessments were completed the assessment should be transmitted to the CMS database within the designated timeframe.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILORA LAKE HEALTHCARE CENTER	**6001 WILORA LAKE ROAD CHARLOTTE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 2 An interview was completed with the Administrator on 2/12/2025 at 11:00 AM who stated MDS assessments should be transmitted within the designated timeframe.