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	345570	A. BUILDING _____ B. WING _____	C 05/07/2025

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HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 05/04/25 through 05/07/25. The facilty was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # U90711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 05/04/25 through 05/07/25. Event ID #U90711. The following intakes were investigated NC00224819, NC00224940, NC00225036, NC00225818, NC00226129, NC00227809, NC00229915 and NC00230019. 1 of the 21 complaint allegations resulted in deficiency.	F 000		
F 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and	F 627		5/30/25

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

Electronically Signed | 05/23/2025

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appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F)The facility ceases to operate.

§483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i)Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

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F 627	Continued From page 2	F 627		

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

§483.15(c)(7) Orientation for transfer or discharge.
A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

§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

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(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 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.

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

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(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that

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F 627	Continued From page 5 the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party, Medical Director, and staff interviews, the facility failed to ensure a safe and orderly discharge when the facility failed to remove a midline catheter (a long peripheral intravenous catheter, typically 6-15 centimeters in length, that is	F 627	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s	

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F 627	Continued From page 6 inserted into a large vein in the upper arm or forearm) before discharging a resident home for 1 of 3 residents reviewed for discharge (Resident #229). The findings included: Resident #229 was admitted to the facility 11/11/24 with diagnoses that included dysphagia and hyponatremia. The admission Minimum Data Set (MDS) assessment dated 11/16/24 indicated Resident #229 had moderate cognitive impairment. A review of Resident #229's physician orders revealed an order dated 12/10/24 that read in part; midline [catheter] to be placed one time a day for hydration. Resident #229 had a physician's order dated 12/11/24 for an intravenous solution of one liter of normal saline at 75 milliliters (ml) per hour given one time on 12/11/24 for hyponatremia. A review of Resident #229's discharge summary dated 12/20/24 and signed by Nurse #1 revealed no devices including a midline catheter were indicated. The discharge summary revealed that there were no orders that required a midline IV access upon discharge. A telephone interview with Resident #229's Responsible Party (RP) occurred on 5/7/25 at 9:37 AM. He stated on the day of Resident #229's discharge, he received medications from the nursing staff and took Resident #229 home. The RP could not remember what education he received before discharge from the nursing staff.	F 627	allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F627 1. On 12/20/24, after being notified by the nurse that Resident #229 was discharged with a midline catheter still in place, the Director of Nursing (DON) immediately went to the resident□s home and safely removed the midline catheter. Resident #229 did not suffer any adverse effects. 12/20/24 the DON completed education with the nurse and unit manager. 2. All residents with an indwelling midline catheter or peripheral IV access are at risk. 3. The staff development coordinator (SDC) will educate all licensed nurses on removing any Intravenous access prior to discharge unless ordered by a provider to continue. This education will be completed by 5/30/2025. Licensed nurses not receiving this education by 5/30/3035 will be educated prior to the start of their shift by the SDC or designee. New licensed nurses will receive education by the SDC or designee during the orientation process. 4. The DON and/or designee will conduct audits 5 times per week for 2 weeks, followed by 3 times per week for the next 2 weeks, then weekly for 4 weeks, then monthly x 1. 5. Audit results will be reviewed during the QAPI meetings to assess compliance	

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F 627	Continued From page 7 He stated when Resident #229 arrived home, she (Resident #229) pointed to her right arm to the midline IV still in place. The RP stated he called the facility and made them aware of the IV that remained in Resident #229's arm. An interview conducted with Unit Manager #1 on 5/7/25 at 12:02 PM revealed Resident #229 had a midline IV in place while she was at the facility. He stated he could not recall the specifics of Resident #229's discharge but stated generally when residents were discharged, an assessment would be completed beforehand and if there was no need for an IV after discharge, the midline catheter would be taken out. Unit Manager #1 also indicated all education was typically completed with residents and families before discharge. An interview with Nurse #1 on 5/7/25 at 2:21 PM indicated the discharge for Resident #229 was rushed due to her wanting to go home and could not recall what education had been given to Resident #229 and her RP. He did not recall if Resident #229 had an IV when he discharged her on 12/20/24. Nurse #1 stated he later found out that the Director of Nursing (DON) went to Resident #229's home after her discharge to remove the midline catheter that was left in place. An interview with the Therapy Director on 5/7/25 at 11:45 AM revealed he worked with Resident #229 after her admission to the facility and she experienced an acute decline which ended her rehabilitation stay and she wanted to return home. He stated he worked with the Discharge Planner on the needed durable medical equipment she needed to be successful at home. The Therapy Director explained all resident	F 627	and determine if further action or resolution is necessary. 6. Date of Completion 5/30/2025	

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discharges were discussed at the interdisciplinary team (IDT) meetings each week.

An interview with the Discharge Planner occurred on 5/7/25 at 3:00 PM. She started discussing discharge planning at the care plan meeting with each resident. The Discharge Planner stated when therapy is coming to an end, she discusses what type of equipment is needed for discharge or any other resources required after the resident's facility stay. She stated IDT meetings were held twice a week and upcoming discharge needs from therapy, nursing, and discharge planning were discussed then.

An interview conducted with the Director of Nursing (DON) on 5/7/25 at 3:12 PM revealed Resident #229 had a midline catheter while at the facility. The DON stated nursing staff alerted her that Resident #229 was discharged home with the midline catheter in her arm. She could not recall which staff member informed her. The DON stated she went to Resident #229's home and removed the midline catheter later that day on 12/20/24. She stated the midline catheter should have been removed during an education session with Resident #229 and her RP before she discharged home because she no longer required the IV fluids for hyponatremia.

An interview with the Medical Director on 5/7/25 10:35 AM revealed she did not recall Resident #229's discharge but stated if the midline catheter was in place, it should have been removed before she left the facility and was an oversight by nursing staff in this instance.

An interview with the Administrator was conducted on 5/7/25 at 3:36 PM. He stated the

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F 627	Continued From page 9 midline catheter in Resident #229's arm should have been removed by nursing staff prior to discharge.	F 627		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Preadmission Screening and Resident Review (PASRR) level II for a resident with a level II PASRR that expired prior to admission to the facility. This deficient practice occurred for 1 of 2 residents reviewed for PASRR (Resident #43). The findings included: Resident #43 was admitted to the facility on	F 644	F 644 1. The facility failed to complete a Preadmission Screening and Resident Review (PASRR) level II for a resident with a level II PASRR that expired prior to admission to the facility. This deficient practice occurred for 1 of 2 residents reviewed for PASRR (Resident #43). Resident #43 had a PASARR Level II that expired prior to admission and was not	5/30/25

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F 644	Continued From page 10 4/16/25 with diagnoses that included bipolar disorder. Review of the PASRR level II dated 2/28/25 revealed it expired on 3/30/25 prior to Resident #43's admission to the facility 4/16/25 and a level II PASRR had not been obtained since admission. An interview conducted with the Assistant Discharge Planner 5/06/25 at 11:24 AM revealed she had been working at the facility for approximately four months. She indicated when a resident was admitted to the facility the PASRR was completed by the hospital prior to admission. The Assistant Discharge Planner stated she used the Medicaid Uniform Screening Tool (MUST) to access the completed PASSR and then entered it into the resident's electronic medical record (EMR). The Assistant Discharge Planner revealed she was unaware Resident #43 had a level II PASRR that expired, she thought it was a PASRR level I, and did not obtain a new PASRR level II for Resident #43. An interview with the Discharge Planner on 5/06/25 at 10:45 AM revealed she and the Assistant Discharge Planner were responsible for monitoring and completing all level II PASRRs. She stated the Assistant Discharge Planner reviewed Resident #43's PASRR when she was admitted but was unaware the PASRR was a level II that had expired. The Discharge Planner indicated a level II PASRR should have been obtained for Resident #43 but was overlooked. During an interview with the Administrator on 5/06/25 at 5:35 PM he revealed the Discharge Planner and Assistant Discharge Planner were	F 644	renewed. A new PASARR Level II referral has been submitted to the State Mental Health Authority as of 05/6/25. 2. Current residents in the center audited by 5/23/2025 to ensure PASRRs are in place. Audit completed by Director of Discharge planning. 3. Audit was completed on 5/6/2025 to identify patients with expired PASRRs. The facility administrator provided education to discharge planning department members on 5/6/2025 regarding how to check for PASRR and to ensure that all residents have a PASRR when admitted. Any member of the discharge planning team not receiving education will be educated prior to the start of their shift by the facility administrator or designee. New discharge planning members will receive orientation during the orientation process from the facility administrator. 4. The director of discharge planning will conduct audits to ensure all residents have PASRRs 5x/wk x 2weeks, then 3x/wk x 2weeks, then weekly x4 weeks, and then monthly x 1 The regional discharge planning specialist will conduct a weekly audit to ensure all residents have PASRRs weekly x 4 weeks, then monthly x 2 5. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary 6. Date of completion on 5/30/25.	

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F 644	Continued From page 11 responsible for monitoring and ensuring all level II PASRRs were obtained. He stated if a resident was admitted with a PASRR level II that was expired then a new level II PASRR should be obtained.	F 644		
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, resident and staff interviews, the facility failed to provide a bagged meal or snack for 1 of 1 resident reviewed for dialysis (Resident #83). The findings included: Resident #83 was admitted to the facility on 5/01/25 with diagnoses that included stage 5 chronic kidney disease. Resident #83's admission assessment dated 5/01/25 indicated she was cognitively intact and oriented to person, place, time and situation. The admission Minimum Data Set (MDS) was in progress and no information was available. A physician's order dated 5/01/25 revealed Resident #83's dialysis treatments were Mondays, Wednesdays, and Fridays at 12:25 PM.	F 698	F 698 1. Resident #83, who receives dialysis treatments on Mondays, Wednesdays, and Fridays, did not receive a bagged lunch on May 2, 2025, and May 5, 2025. The resident was promptly assessed for any adverse outcomes related to the missed meals during dialysis transport on those dates. No negative effects were identified. On May 7, 2025, a meeting was held with the resident, the dietary manager, and the assigned nursing staff to apologize and to discuss the resident's preferences and expectations for meal support on dialysis days. To prevent recurrence, a new process has been implemented: the dietary team will prepare clearly labeled, individualized bagged lunches for dialysis days, and nursing staff will be responsible for retrieving them prior to the resident□s transport to dialysis. This ensures	5/30/25

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	345570	A. BUILDING _____ B. WING _____	C 05/07/2025

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HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 698	Continued From page 12 An interview conducted with Resident #83 on 5/06/25 at 12:30 PM revealed she was admitted to the facility from the hospital on 5/01/25 for short term rehabilitation. She stated during her hospital stay she started dialysis treatments and was continuing treatments at an outpatient dialysis center on Mondays, Wednesdays and Fridays. Resident #83 revealed the facility transported her to the dialysis center on 5/02/25 and 5/05/25, and she left the facility at 11:15 AM and returned around 5:00 PM. She indicated she had breakfast at 8:00 AM before she left for dialysis but was "starving" when she returned to the facility. Resident #83 revealed a bagged lunch was not provided and she was unsure if that was something the facility offered but it would be nice to have on the days she went to dialysis. During an interview with the Dietary Manager on 5/06/25 at 4:56 PM she indicated bagged lunches were prepared and kept in the kitchen for residents that went to dialysis. She stated nursing staff were responsible for getting a bagged lunch from the kitchen to send with the resident to dialysis. The Dietary Manager revealed she was unaware a bagged lunch was not sent with Resident #83 to dialysis and was unsure as to why because a bagged lunch was prepared and available in the kitchen on 5/02/25 and 5/05/25. An interview conducted with Nurse Aide #1 (NA) on 5/07/25 at 9:00 AM revealed she was assigned to Resident #83 on 5/02/25 and 5/05/25. NA #1 stated when one of her assigned residents was going to dialysis, she was responsible for getting a bagged lunch from the kitchen to send with the resident. NA #1 indicated on 5/02/25 and 5/05/25 Resident #83	F 698	Resident #83 consistently receives appropriate nutrition support on treatment days. 2. A facility-wide audit was initiated and completed on 5/5 to identify all residents currently receiving dialysis services. No additional instances of missed meals were identified. Current dialysis residents interviewed by nursing leadership to determine if they are receiving food to take to dialysis with them. This was completed by 5/23/20205/ 3. Facility-wide education was initiated by the staff development coordinator on 5/5/25 for nursing staff, CNAs, and dietary personnel regarding the expectation that all residents receiving outpatient dialysis must be provided with a bagged lunch prior to leaving the facility for their appointment. Any staff who have not received this education by 5/30/2025 will receive the education prior to the start of their shift. New staff will receive this education during the orientation process, 4. The receptionist will receive additional training to ensure that all patients departing for dialysis are provided with a lunch bag. All receptionists will be educated by 5/27/25. All new receptionists will receive education during facility orientation. 5. The DON and/or designee will conduct interviews with patients who receive dialysis 5 times per week for 2 weeks, followed by 3 times per week for the next 2 weeks, then weekly for 4	

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F 698	Continued From page 13 went to dialysis without lunch because she forgot to get her bagged lunch from the kitchen. An interview conducted with the Medical Director on 5/07/25 at 9:50 AM indicated Resident #83 not having lunch when she went for dialysis was not ideal, however she would not have any adverse outcomes. The Medical Director stated a bagged lunch should be provided and sent with Resident #83 on the days she went for dialysis treatment. An interview conducted with the Administrator on 5/06/25 at 5:45 PM indicated bagged lunches were prepared and available for residents on the days they went to dialysis and should be sent with the resident.	F 698	weeks, then monthly x 1. 6. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. The director of nursing and administrator are responsible for implementing and maintaining an acceptable plan of correction. 7. Date of Completion 5/30/2025.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	F 880		5/30/25

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F 880	Continued From page 14	F 880		

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 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

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F 880	Continued From page 15 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 review, and staff interviews, the facility failed to follow their Hand Hygiene policy when the Treatment Nurse did not perform hand hygiene before each donning of clean gloves while providing wound care to Resident #53. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (Treatment Nurse). The findings included: Review of the facility's policy and procedure entitled Hand Hygiene read in part: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: - When coming on duty. - Before and after assisting a patient with personal care (e.g., oral care, bathing). - Before and after changing a dressing. - After any contact with potentially contaminated materials (used wound/treatment dressings). A wound observation was made on 05/07/25 at 9:54 AM on Resident #53 with the Treatment Nurse. The Treatment Nurse was observed cleaning the bedside table with disinfectant wipe and placed her wound supplies on the table after it dried. The Treatment Nurse washed her hands	F 880	F 880 1. During an observation on 05/07/25, the Treatment Nurse failed to perform proper hand hygiene between glove changes while providing wound care to Resident #53. The facility□s hand hygiene policy mandates hand hygiene after glove removal and before donning new gloves, particularly during dressing changes and contact with potentially contaminated material. This practice deficiency was observed in 1 of 4 staff reviewed for infection control procedures. The wound care procedure was immediately reviewed by the DON and Infection Preventionist (IP) following the observation on 5/7/25 to ensure that no signs or symptoms of infection were present in the affected wound sites. 2. Wound nurse was educated on 5/7/25 regarding wound care practices and the facilities hand hygiene policy. Wound care nurse verbalized understanding. Demonstrated proper hand hygiene and glove use during a return demonstration evaluated by the IP on 05/08/25. Competency was successfully validated and documented. Education completed by our center□s staff development coordinator.	

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F 880	Continued From page 16 in Resident #53's bathroom using soap and water, then donned a clean gown and clean gloves. She then removed the old dressing from the residents left posterior thigh and placed the soiled dressing into the trash can. The Treatment Nurse went into Resident #53's bathroom and washed her hands. She then, donned a clean pair of gloves and proceeded to clean the area around the wound with a wound care solution. She applied skin prep to the outer portion of the wound, then doffed her gloves without sanitizing her hands, donned clean gloves and packed the wound with a wet to dry dressing packing the gauze into the residents wound with her finger and a Q-tip. She then doffed her gloves and without sanitizing her hands, donned clean gloves and moved to Resident #53's second wound located on the left thigh. She cleaned the wound with skin prep and applied Calcium Alginate to the area with a dry dressing. The Treatment Nurse then doffed her gloves and without sanitizing her hands, donned clean gloves to assist Resident #53 adjust her pants back up in the correct position and placed a wedge under the residents left side. She then doffed her gown, washed her hands with soap and water, collected her supplies and trash and wiped down the table and left the resident's room. An interview conducted on 05/07/25 at 10:20 AM with the Treatment Nurse revealed she was not aware that she had not sanitized her hands each time she had doffed her gloves. She stated she had to change gloves so much during the wound care that she must have forgotten to always sanitize her hands when she removed her gloves. The Treatment Nurse further stated she knew she was supposed to always sanitize her hands when she removed her gloves each time and	F 880	3. Current licensed nurses were educated on proper hand hygiene during wound care treatment and to wash/sanitize hand between any glove change, education completed by the staff develop coordinator. Treatment observation for current licensed nursing staff was conducted between 05/08/25 and 05/13/25 by the staff development coordinator. Any licensed nurse who did not complete the training during this period will receive the required education prior to the start of their next scheduled shift by the staff development coordinator. New licensed nursing hires will be required to complete the treatment observation tool to ensure proper hand hygiene during wound care. 4. The staff develop coordinator, or designee will conduct hand hygiene audits using the treatment observation tool to wound nurse 5 treatments per week for 2 weeks, followed by 3 treatment observations per week for the next 2weeks, then once weekly for 4 weeks, then once monthly x 1. 5. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. The director of nursing and administrator are responsible for implementing and maintaining an acceptable plan of correction. 6. Date of completion 5/30/2025	

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before putting on clean gloves and typically had hand sanitizer with her in the room however she was just nervous.

An interview conducted on 05/07/25 at 10:38 AM with the Infection Preventionist (IP) revealed she was not aware of the errors made by the Treatment Nurse during wound care. She stated her expectation was that she would sanitize her hands every time that she removed her gloves and before putting on clean gloves during wound care. The IP further stated staff received education on infection control annually and multiple times during the year.

An interview on 05/07/25 at 1:03 PM with the Director of Nursing (DON) revealed she was aware of the Treatment Nurse's errors during wound care and said she had been provided with additional education regarding doffing and donning and sanitizing in between glove changes. The DON stated it was her expectation that the Treatment Nurse follow infection control best practices to avoid introducing microorganisms into the wounds. She further stated there was a lot of donning and doffing and she felt the Treatment Nurse had just become nervous during the observation.

An interview on 05/07/25 at 3:35 PM with the Administrator revealed he would expect the Treatment Nurse to follow the Hand Hygiene policy for wound care.

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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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge location for 1 of 5 residents (Resident #77) reviewed for accuracy of assessment. The findings included: Resident #77 was admitted to the facility on 11/25/2024. Review of a discharge planning note dated 2/18/2025 at 3:01 PM revealed Resident #77 had a planned discharge to home with home health services. Review of a nursing note dated 2/19/2025 at 4:34 PM revealed Resident #77 discharged home. Review of the discharge MDS dated 2/19/2025 revealed that the discharge status had been coded as discharge to short-term general hospital. An interview on 5/6/2025 at 9:22 AM with the lead MDS Coordinator indicated Resident #77 had discharged home with home health services and the discharge MDS had been coded incorrectly. She did not know why this had occurred.

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:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1 An interview on 5/7/2025 at 8:20 AM with MDS Coordinator #1 indicated she had coded the discharge status incorrectly as discharge to short-term general hospital and stated Resident #77 discharged home with home health. She stated the mistake was not intentional. An interview on 5/7/2025 at 12:41 PM with the Administrator indicated that the MDS should be coded accurately.