STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034100	A. BUILDING: _____ B. WING _____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT AT UNIVERSITY PLACE	1635 EAST 5TH STREET WINSTON SALEM, NC 27101

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on 09/14/21 through 09/15/21 with an exit conference via telephone on 09/16/21.	D 000	Please find the enclosed Plan of Correction for the Annual survey conducted on 9/14/2021-09/16/2021. The submission of this Plan of Correction does not constitute agreement, or admission by Somerset Court at University Place of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction has been prepared and submitted because of the requirement under state & federal law. Please accept this Plan of Correction as our credible allegation of compliance. Please find sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the facilities allegation of compliance.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff assisted 1 of 5 sampled residents (#4) in providing catheter care, toileting, showers and grooming according to the resident's care plan. The findings are: Review of Resident #4's current FL2 dated 02/15/21 revealed: -Diagnoses included pulmonary tuberculosis, severe malnutrition, dysphagia, and hypertension. -He was intermittently disoriented and had an indwelling Foley catheter. Review of Resident #4's Resident Register revealed an admission date of 07/09/15.	D 269	Facility Plan of Correction in reference to D 269 10A NCAC 13F .0901 Personal Care and Supervision TYPE B VIOLATION shall be as follows: All Medical Care staff shall complete Urinary Catheter Care & Drainage Bag Care conducted by ACD. RCC & LSIC shall conduct training & review of Personal Care targeting areas of toileting, showers, and grooming with all Medical Care staff. Resident #4 was issued a 30-day discharge on 09/15/2021 and guardian was notified 09/15/2021 in compliance with 10A NCAC 13F .0702 due to the resident's needs & welfare not being able to be met due to the residents continued refusal of care as documented by the resident's physician. The MT will document any refusals made by resident #4 regarding personal care involving all Medical Care staff inside & outside the facility. The RCC shall then notify residents guardian & ED of any refusals concerning care. The RCC, Maintenance Director, ACD or designee will monitor (3) random resident rooms for cleanliness 2 times a week for 4 weeks, then 1 time a week for 8 weeks to ensure 100% compliance.	10/31/2021

10/15/21 Reviewed and Acknowledged KMPolce

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D 269	Continued From page 1 Review of Resident #4's Care Plan, signed by his primary care physician (PCP) on 08/19/21, revealed: -He had an indwelling catheter and was not to care for the catheter himself. -He was to be provided total care by the staff for bathing, dressing and grooming. -He was to be provided limited care for eating and toileting. -He was independent with ambulation. Review of Resident #4's Licensed Health Professional Support (LHPS) documentation dated 07/05/21 revealed: -Personal care tasks provided by the staff were positioning and emptying the urinary catheter bag and cleaning around the urinary catheter. -The frequency of the staff cleaning (around the urinary catheter) was every 2-3 hours. -The positioning of the drainage bag was to be below the level of the waist. Observation during the initial tour of the facility on 09/14/21 from 8:45am -10:10am revealed: -Resident #4's bedroom door was closed while touring the 200 hall. -The resident did not respond to a knock on his door. -The surveyor identified herself and asked if she could enter. -The resident answered, "Get out of my room." -The surveyor returned shortly with the medication aide (MA) who was administering morning medications to the resident. -The curtains were drawn with no light, and the room had a musty, urine smell. -The resident was lying in bed with a stained blanket pulled up to his waist. -His shirt was stained, his hair was matted and he was unshaven.	D 269		

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D 269	Continued From page 2 -His fingernails were dirty and overgrown, as were his toenails when exposed by the MA. -He refused to allow an inspection of his catheter or genital area. -The catheter bag was outlined parallel to his left hip on the bed under the covers. -On the stained rug were several small clumps of dried feces. -In the wastebasket by the door were briefs with dried feces, and dried feces were along the sides of the wastebasket. Interview with the housekeeper on 09/14/21 at 10:05am revealed: -Resident #4 did not allow anyone in his room. -He would yell and tell anyone entering to "get out of his room". Interview with two personal care aides (PCAs) on 09/14/21 at 12:10pm revealed: -Resident #4 has become increasingly resistant to care in the past several months. -He had pulled his catheter out a few times recently. -He did not let anyone provide personal care to him. -They had not provided catheter care to him, "maybe the MAs have." -He refused showers and to change his clothing. -They thought he emptied his own catheter bag. -The PCAs changed his bed when he was out of his room and emptied the trash barrel since it was usually right by the door. -He came out of his room occasionally to go to the snack machine and then immediately returned to his room. -They could not recall the last time his bed was changed but it should be changed on his shower days.	D 269		

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D 269	Continued From page 3 Interview with a first shift MA on 09/14/21 at 12:20pm revealed: -Resident #4 always was a challenge to provide care for. -He usually took his medications in the morning, but he refused his showers, changing his sheets and taking care of his catheter regularly. -He did not let anyone shower him. -She had not provided catheter care to Resident #4. -She thought he was independent with daily catheter care and when the Home Health nurse visited, she would clean the catheter and make sure it was properly placed. Review of the facility's shower schedule, from 06/01/21 through 09/15/21 revealed: -Resident #4 was scheduled for showers three times a week on third shift. -There was no documentation of showers administered on those days for the resident. Review of Resident #4's June 1, 2021 through September 15, 2021 electronic medication administration record (eMARs) revealed: -There were no entries for catheter care or emptying of the Foley bag on the eMARs. -There was no documentation catheter care had been provided on the electronic progress notes. Review of Resident #4's June 1, 2021 through September 15, 2021 electronic treatment record (eTARs) revealed: -There were no entries for catheter care or emptying of the Foley bag on the eTARs. -There was no documentation catheter care had been provided on the electronic progress notes. Telephone interview with Resident #4's primary care physician (PCP) on 09/15/21 at 10:10am	D 269		

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D 269	Continued From page 4 revealed: -She had been on leave for the past 3 months. -She had been providing care to Resident #4 for over a year and he had always been resistant to care, including her visits and assessments. -During the past year, staff reported he did not allow them to provide personal care or catheter care. -She did not having any documentation that Resident #4's catheter was being flushed or changed monthly. -She did not know he had been diagnosed at the Emergency Department (ED) on 06/03/21 with sepsis, a urinary tract and kidney infection and a catheter malfunction. -Based on the decline of cognition due to his prostate cancer diagnosis, and the continued decline as the disease progresses, he would not be able to receive the services he needed in an assisted living setting. Observation of Resident #4 on 09/15/21 at 1:10pm revealed: -Resident #4 was in his bedroom with the door shut. -The MA accompanied a surveyor upon entering the resident's room. -The surveyor requested permission to observe the foley catheter which was under the bedcovers. -The resident refused and shouted for the MA and the surveyor to get out of his room and close the door. Interview with Resident #4's guardian on 09/15/21 at 9:45am revealed: -Resident #4 had always been a challenge due to his fierce independence and resistance to care. -She thought he was still under the care of Hospice who was providing bed baths and	D 269		

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D 269	Continued From page 5 catheter care. -She did not know Hospice services ended on 05/14/21. -He was resistant to care and she did not think another placement would be more successful in providing personal care. -The staff should be able to redirect him and provide the care he needed. Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 11:35am revealed: -In October 2020 when she initially started in her current position, Resident #4 was combative and refused care. -The expectation for catheter care for a resident was for the MAs to clean the tubing from any debris, and the CNAs or MAs to empty the catheter bag each shift. -She knew the resident was resistant to care and the staff were unable to provide for his personal care needs, catheter care, changing briefs and showers. -She informed the interim PCP and she attempted to get outside services to assist in this care, specifically home health and hospice. Review of Resident #4's hospital discharge summary on 06/03/21 revealed: -Resident #4 presented to the ED with complaints of Foley catheter pain. -Initial laboratory results showed a urinary tract infection, a kidney infection, sepsis and a catheter malfunction. Interview with Area Director of Operations on 09/15/21 at 10:55am revealed: -He was not aware of the challenges Resident #4 presented with personal care, including catheter care. -He had initiated a Care Plan meeting next week	D 269		

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D 269	Continued From page 6 to discuss with the resident, his guardian and the Administrator the personal care tasks he would have to allow the staff to provide him. -If he would not allow staff to provide these care tasks, a discharge would be issued. Interview with the Licensed Health Professional Support (LHPS) Registered Nurse on 09/15/21 at 12:05pm revealed: -She checked off the MAs and PCAs on catheter care with return demonstration before the staff began working on the floor. -She also provided an annual refresher course on catheter care for the staff. -She thought the last training was the first quarter of this year. Interview with the Administrator on 09/15/21 at 11:55am revealed: -She had assumed her current position one week ago. -She was not familiar with all the residents yet. -Her expectation for a resident that had a catheter placed was that the MAs or PCAs would clean the tubing and wipe the area surrounding the placement each shift, or as needed. -The PCAs or MAs should empty the catheter bag each shift and observe the color of the urine. -The PCP should be notified if there were any skin irritation, foul smell or dark/bloody urine in the bag. Attempted telephone interview with third shift PCA was unsuccessful. Attempted telephone interview with the HH RN on was unsuccessful. The facility failed to provide personal care for Resident #4, including catheter care, according to	D 269		

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D 269	Continued From page 7 his care plan, which resulted in the resident being admitted to the Emergency Department with a urinary tract infection, a kidney infection and sepsis. This failure was detrimental to the residents' health and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on September 15, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED October 31, 2021.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to ensure referral and follow up to meet the acute healthcare needs for 1 of 5 sampled residents (#4) who had an indwelling catheter and an order for monthly catheter changes as ordered by the urologist. The findings are: Review of Resident #4's current FL2 dated 02/15/21 revealed: -Diagnoses included pulmonary tuberculosis, severe malnutrition, dysphagia, and hypertension. -He was intermittently disoriented and had an	D 273		

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D 273	Continued From page 8 indwelling Foley catheter. Review of Resident #4's Resident Register revealed an admission date of 07/09/15. Review of Resident #4's Care Plan, signed by his primary care physician (PCP) on 08/19/21, revealed he had an indwelling catheter and was not to care for the catheter himself. Review of Resident #4's Urologist visit notes dated 08/06/20 revealed: -He performed a catheter change for the resident and prescribed Cipro 500mg, one time dose, to prevent infection. -The resident was to follow up monthly for catheter changes. -There was no further documentation of urology visits for the resident. Review of Resident #4's home health registered nurse (HH RN) visit notes revealed: -On 01/09/21 there was documentation the resident was seen in the emergency department (ED) for a UTI on 01/05/21. -The RN changed the resident's catheter at this time. -The next documented visit note was on 03/09/21 when she performed a catheter change. -On 04/08/21, there was documentation the RN performed another catheter change. -The last entry on the HH progress notes was on 09/08/21 when the resident refused a catheter change, "go back out the door you came in". Review of Resident #4's hospice RN visit notes revealed: -Hospice's start of service was 03/12/21. -The plan of care was to include monthly catheter changes.	D 273		

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D 273	Continued From page 9 -On 03/24/21, 04/12/21 and 04/27/21, the resident refused to allow the RN to "touch him". -There was no documentation of a successful catheter change during these visits. -Hospice discharged the resident from services on 05/14/21. Observation during the initial tour of the facility on 09/14/21 from 8:45am -10:10am revealed: -Resident #4's bedroom door was closed while touring the 200 hall. -The resident was lying in bed with a stained blanket pulled up to his waist. -He refused to allow an inspection of his catheter or genital area Interview with Resident #4's guardian on 09/15/21 at 9:45am revealed: -Resident #4 had always been a challenge due to his resistance to care. -She thought he was still under the care of hospice who was providing catheter care, including monthly changes. -She did not know hospice services ended on 05/14/21. Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 11:35am revealed: -In October 2020, when she initially started in her current position, Resident #4 was combative and refused care. -She informed the interim PCP and she attempted outside services, hospice and home health, to assist in this care. -These agencies were performing catheter changes monthly when he would comply. -She had to send him to the Emergency Department (ED) everytime he pulled out his catheter because the staff were not licensed to perform a catheter change.	D 273		

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D 273	Continued From page 10 -From October 2020 through May 14, 2021, Resident #4 was receiving services with hospice and home health agencies respectively. -She thought the hospice nurse and the home health nurse were performing monthly catheter exchanges. -She did not have any home health or hospice services from May 14th, 2021 through August 18, 2021 to provide catheter changes for Resident #4. -She was not aware that much time had elapsed between catheter changes. -On 08/09/21, the resident was very agitated and pulled out his catheter which required a visit to the ED. -She contacted the interim PCP after the ED visit and requested an order for HH to begin services for nursing to take care of the catheter changes again. Review of Resident #4's hospital discharge summary dated 06/03/21 revealed: -Resident #4 presented to the ED with complaints of Foley catheter pain. -Initial laboratory results showed a urinary tract infection, a kidney infection, sepsis and a catheter malfunction. -The ED RN exchanged the resident's catheter at this time. Review of Resident #4's hospital discharge summary dated 08/09/21 revealed: -Resident #4 presented to the ED with staff reporting his catheter had not been changed "in a long time" and he had "pulled it out today". -His urine was cloudy and had a foul smell. -Laboratory testing confirmed Resident #4 had a urinary tract infection. -His catheter was changed with recommendations to follow up with his PCP.	D 273		

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D 273	Continued From page 11 Review of HH visit notes dated 09/15/21 revealed: -The RN observed a catheter bag in the trash can by Resident 4's bedroom door. -The resident would not allow the HH RN to change the catheter. -"Get the (expletive) out of my room." -The RN was able to place a new bag on the catheter. Telephone interview with Resident #4's PCP on 09/15/21 at 10:10am revealed: -She referred him to a urologist in February of 2021, with the recommendation he should return monthly for catheter changes. -She did not have a record of any return visits to the urologist since February 2021. -Before she went on a leave of absence, she thought his catheter changes were being completed by the hospice RN during her monthly visits. Interview with the Administrator on 09/15/21 at 11:55am revealed: -She had been in her current position for one week. -She did not know Resident #4 was not receiving catheter changes for his Foley catheter from a provider from 05/14/21 through 08/18/21. -It would be the responsibility of the RCC and the previous Administrator to have providers to change Resident #4's foley catheter. Attempted interview with Resident #4 on 09/14/21 at 9:50am and 09/15/21 at 1:10pm was unsuccessful. Attempted telephone interview with Resident #4's Urologist on 09/16/21 at 9:57am was	D 273		

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D 273	Continued From page 12 unsuccessful. The facility failed to ensure Resident #4 was provided monthly catheter changes as prescribed by the urologist. This failure resulted in repeated visits to the ED to replace the Foley catheter and repeated urinary tract and kidney infections. This failure was detrimental to the health of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2021.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the failed to clarify an physician's order	D 344	Facility Plan of Correction in reference to D 273 10A NCAC 13F .0902(b) Health Care and D 344 10A NCAC 13F .1002(a) Medication Orders shall be as follows: All Medical Care Staff will be in-serviced on catheter care with ACD. Catheter Care has been added to MAR for staff notifications. Refusals will be documented & RCC will notify Physician & guardian of any refusals made. Resident #4 will have MAR monitored daily for as long as Resident #4 has catheter and/or in our care. RCC, ACD, or designee will monitor 3 random resident records 2 times a week for 4 weeks, then 1 time a week for 8 weeks to ensure new orders have been sent to pharmacy if needed, new orders have been sent to lab if needed, new orders have been filed in chart & documentation of provider notification for clarification, follow-up & any medication discrepancies.	10/31/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034100	A. BUILDING: _____ B. WING _____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT AT UNIVERSITY PLACE	1635 EAST 5TH STREET WINSTON SALEM, NC 27101

(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) COMPLETE DATE
D 344	Continued From page 13 for a blood thinning medication for 1 of 5 residents. (Resident #1) The findings are: Resident #1's current FL2 dated 08/26/21 revealed: -Diagnoses included fracture of the upper left tibia, fracture of the upper left fibula, unspecified fall, type 2 diabetes, peripheral neuropathy and Parkinson's disease. -An order for enoxaparin sodium, (a blood thinning medication), 40mg injection was scheduled for every 12 hours. Review of Resident #1's progress notes for 08/27/21 revealed: -Resident #1 was readmitted to the facility from a skilled nursing/rehabilitation facility on 08/27/21. -At 7:43pm the MA documented Resident #1's readmission medications had been clarified and faxed to the pharmacy. Review of Resident #1's July 2021 electronic medication administration record (eMAR) revealed: -There was not an entry for enoxaparin sodium 40 mg injection scheduled for every 12 hours. -There was no documentation enoxaparin sodium 40 mg injection was administered. Review of Resident #1's August 2021 eMARs revealed: -There was not an entry for enoxaparin sodium 40 mg injection scheduled for every 12 hours. -There was no documentation enoxaparin sodium 40 mg injection was administered. Review of Resident #1's September 2021 eMARs:	D 344		

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D 344	Continued From page 14 -Revealed there was not an entry for enoxaparin sodium 40 mg injection scheduled for every 12 hours. -There was no documentation enoxaparin sodium 40 mg injection was administered. Review of Resident #1's medications on hand on 09/15/21 at 2:30pm revealed enoxaparin sodium was not available for administration for Resident #1. Interview with a medication aide (MA) on 09/15/21 at 2:30pm revealed she did not remember administering enoxaparin sodium to Resident #1. Telephone interview with the pharmacy tech at the facility's contracted pharmacy on 09/15/21 at 1:31pm revealed: -Enoxaparin sodium 40mg scheduled for every 12 hours had not been dispensed to the facility because the pharmacy required a clarification of the order. -The pharmacy faxed and called the facility for clarification of the order on 08/27/21 as well as 08/28/21 but did not receive a response. -The pharmacy did not contact the provider because they did not have the provider's fax number. Telephone interview with the Lead MA on 09/16/21 at 10:24am revealed: -The facility sent residents' updated FL2s to the pharmacy to communicate medication changes. -When the pharmacy delivered the medications to the facility they were checked against the FL2 by the Resident Care Coordinator (RCC) or MA before the medications were put away on the medication cart. -If a medication was not delivered, the RCC or	D 344		

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D 344	Continued From page 15 MA would have contacted the pharmacy and the provider to resolve the issue, and the communication was documented in the resident's progress notes. -She did not remember contacting the pharmacy or provider about Resident #1's enoxaparin sodium order. -She did not remember the pharmacy contacting the facility for clarification of Resident #1's enoxaparin sodium order. Interview with the RCC on 09/15/21 at 3:15pm revealed: -When a resident stayed more than 72 hours at the hospital, their new FL2 was faxed to the pharmacy by the RCC or MA so any new medications could be dispensed. -After the pharmacy delivered Resident #1's medications she or the MA should have compared the medications to the FL2 to ensure that everything was delivered before they were put away on the medication cart. -She or the MA should have called the pharmacy to inquire about the missing medication but she could not remember if this was done since it was not documented in Resident #2's progress notes. -The pharmacy was responsible for contacting the provider if clarification was needed to dispense a medication. -She was responsible for calling the provider to see what the course of action was and document this call in the progress notes. Telephone interview with the Orthopedic Specialist's Medical Assistant on 09/16/21 at 9:46pm revealed: -Resident #1 was seen in the office on 08/12/21 and was instructed to continue enoxaparin sodium 40 mg injections every 12 hours until 08/24/21.	D 344		

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D 344	Continued From page 16 -The medication was prescribed for deep vein thrombosis (DVT) prophylaxis. Interview with the Regional Director of Operations (RDO) on 09/15/21 at 2:15pm revealed: -When a new FL2 for a resident was received, the clinical staff would forward it to the pharmacy. -The pharmacy profiled the resident's medications as listed on the FL2, and they would be entered on their eMAR. -The RCC reviewed the medications entered by the pharmacy and compared their accuracy with the hard copy of the resident's FL2. -If there were no errors in the medication entries, the RCC approved the medication orders and the MAs would observe the entry on the eMAR. -If the medication orders needed to be clarified, the pharmacy would contact the physician directly or contact the clinical team at the facility. -The integrity of the copy of Resident#1's FL2 was insufficient to determine the medication names, dosages or frequency of several of the medications listed. -The RCC should have requested a more legible FL2 from the provider. -He did not know the pharmacy had attempted to contact the facility staff for the providers name and contact information on two occasions.	D 344		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 17 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and healthcare. Based on observations, interviews and record reviews, the facility failed to ensure staff assisted 1 of 5 sampled residents (#4) in providing catheter care, toileting, showers and grooming as designated on his plan of care and Licensed health Professional Support (LHPS) tasks.. [Refer to Tag 0269 , 10A NCAC 13F .0901(a) Personal Care (B Violation).] Based on observations, record reviews and interviews the facility failed to ensure referral and follow up to meet the acute healthcare needs for 1 of 5 sampled residents (#4) who had an indwelling catheter and an order for monthly catheter exchanges. [Refer to Tag 0273 , 10A NCAC 13F .0902(b) Health Care (B Violation).]	D912	Facility Plan of Correction in reference to D 912 G.S. 131D-21(2) Declaration of Residents' Rights shall be as follows: All Medical Care Staff shall review "Residents Rights" to refresh & validate understanding. All new Employees will continue to receive a copy of "Resident Rights" and validate understanding. RCC & LSIC will monitor all nursing staff to ensure "Resident Rights" are being implemented and met by monitoring the care of 3 random residents 2 times a week for 4 weeks, & then 1 time a week for 8 weeks.	10/31/2021