PRINTED: 03/21/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		345441	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	040441	5: 11::10	STREET ADDRESS, CITY, STATE, ZIP CO	DE	02/	17/2022
I WAWL OF TH	NOVIDER OR GOLF EIER			1770 OAK HOLLOW ROAD	JL .		
ALEXAND	PRIA PLACE			GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	complaint survey was through 2/3/22. Addi obtained through 2/17 date was changed to found in compliance	site recertification and seconducted on 1/31/22 tional information was 7/22. Therefore, the exit 2/17/22. The facility was with the requirement CFR Preparedness. Event ID #	F(000			
	complaint investigation 1/31/22 through 2/3/2 was obtained through exit date was change #6KJN11). A total of	legation was substantiated.					
F 580 SS=J	Immediate Jeopardy removed on 2/13/22. An extended survey of Notify of Changes (In CFR(s): 483.10(g)(14) Notific (i) A facility must immediate consistent with his or representative(s) where (A) An accident involved.	ujury/Decline/Room, etc.) (i)-(i)-(iv)(15) cation of Changes. dediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring	F (580			3/11/22
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE			(X6) DATE

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

Electronically Signed

03/11/2022

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345441	B. WING			C 2/17/2022
NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		Z/17/ZGZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
(B) me de state clii (C a r tre co (D res §4 (ii) (14 all is a ph (iii) res wh (A) as (B) State (e) (iv up ph rep §4 Ad that §4 its loo	ental, or psychosocy terioration in health atus in either life-through the inical complications. A need to alter tree at the ed to discontinue atment due to adverse a new form. A decision to transisted from the facil 83.15(c)(1)(ii). When making noting the facil 83.15(c)(1)(ii). When making noting the facil 83.15(c)(1)(ii). When making noting the facility must a sident and the residual and the	ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or beatening conditions or an existing form of erse consequences, or to an of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or as as specified in paragraph ecord and periodically mailing and email) and	F 58	80		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345441	B. WING			С
NAME OF D	DOVIDED OD CUIDDUED	345441	B. WING	CTREET ARRESCO CITY CTATE ZIR CORE	0	2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALEXAND	RIA PLACE			1770 OAK HOLLOW ROAD		
				GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ,		(X5) COMPLETION DATE	
F 580	Continued From page	÷ 2	F 58	0		
	by: Based on record revistaff, and Nurse Prac failed to notify the phy	is not met as evidenced ews, responsible party, titioner interviews, the facility sician of the deterioration of		THE ROOT CAUSE ANALYSIS DIRECTED PLAN OF CORREC WILL FOLLOW AS AN ATTACH	CTION	
	a stage 2 decubitus ulcer (also known as a bed sore that is an injury to the skin and underlying tissues resulting from prolonged pressure on the area) to a stage 4 decubitus ulcer with tunneling and sepsis. The facility also failed to notify the Responsible Party (RP) of the development and deterioration of a pressure ulcer. This was for 1 of 3 residents (Resident #106) reviewed for notification of changes.			THIS PLAN OF CORRECTION ROOT CAUSE ANAYLSIS WAS COMPLETED IN CONJUNCTION	3	
				THE QUALITY ASSURANCE COMMITTEE.		
				ALEXANDRIA PLACE S RESI THIS REPORT OF SURVEY DO DENOTE AGREEMENT WITH STATEMENT OF DEFICIENCIE	OES NOT THE	
	Resident #106 was o deteriorated pressure wound and staff failed The resident was hos she was unresponsiv	Immediate jeopardy began on 12/19/21 when Resident #106 was observed by staff with a deteriorated pressure ulcer with tunneling of the wound and staff failed to notify the physician. The resident was hospitalized on 12/22/21 when she was unresponsive and was diagnosed with a		DOES IT CONSTITUTE AN AD THAT ANY STATED DEFICIEN ACCURATE. WE ARE FILING PLAN OF CORRECTION BECAREQUIRED BY LAW.	MISSION CY IS THE	
	stage 4 decubitus ulcer with tunneling and sepsis and died in the hospital on 12/23/21. The immediate jeopardy was removed on 02/13/22 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example 1b was cited a scope and severity level of "D".			" F-580:		
				CORRECTIVE ACTION(S) THAT BE ACCOMPLISHED FOR THE RESIDENTS FOUND TO HAVE AFFECTED BY THE DEFICIENT PRACTICE:	OSE E BEEN	
				Resident #106 is no longer a re Alexandria Place and therefore interventions are needed for Re 106.	, no	
	The findings included 1. Resident #106 was 09/21/13.	admitted to the facility on		100.		

Facility ID: 923196

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345441	B. WING		02	C / 17/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02	11112022
				1770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	Continued From page	e 3	F 58	0		
	dated 10/07/21 revea cognitively impaired.	terly Minimum Data Set alled she was moderately 2/03/22 at 5:30 PM with		HOW OTHER RESIDENTS HAVE IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAMI		
	revealed she observe and described she ha her bottom and coccy resembled a blister w	vealed she observed Resident #106 on 12/09/21 vealed she observed Resident #106's bottom and described she had several different areas on er bottom and coccyx with one area that sembled a blister with fluid in it. Nurse #1 said the had done the dressing on Resident #106 on 12/09/21, 12/12/21, 12/15/21 and 12/18/21 and		DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT BEEN OR WILL BE TAKEN:		
	said the wound had p and was larger than v 12/09/21. Nurse #1 i contacted the physici	2/15/21 and 12/18/21 and orogressively gotten redder when it was first noted on ndicated she had not an or Nurse Practitioner f the wound's progression		Alexandria Place has identified the residents have the potential to be by this practice.		
	after 12/09/21.	, ,		The facility has designated an Administrative Licensed Practical		
	12/10/21 revealed the for "follow up visit for breakdown." Integun and all its layers) was poor healing of woun	(NP) progress note dated e resident was being seen evaluation of buttocks nentary (includes the skin s noted as being positive for ds. The wounds were		as the individual that will be completing all notifications to the Attending Physician, contract wound doctor, and Responsible Party concerning wounds. This Administrative Licensed Practical Nurse has been in-serviced on 02/11/2022 by an		
	areas with top layer of bilateral upper/poster coccyx."	s as "multiple denuded of skin sheared off over rior thighs, buttocks, and		outside facility consultant concern notifying the attending physician, wound doctor, and Responsible P about any changes to wounds. Th Director of Nursing and two Nurse	contract arty e	
	Aide (NA) #2 reveale Resident #106 on 12 Director of Nursing (I to look at the residen wound was red with s areas and there were	2/22 at 11:49 AM with Nurse d she had taken care of /19/21 and had asked the DON) to come into her room ts wound. NA #2 stated the some bleeding in some areas of black on the ed she could not remember		Managers were also in-serviced be outside facility consultant on the stopic on 02/11/2022. If the Administicensed Practical Nurse is not weathetime that a worsening of the worst noted, the Floor nurse will be responsible Party.	ame strative orking at round is oonsible	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		TE SURVEY MPLETED
				_			С
		345441	B. WING _			۱ ،	2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER		<u>l</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
				17	770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			G	ASTONIA, NC 28054		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 580	Continued From pag	F 5	580				
	the wound having a	foul odor but said it could					
	have and she just di	dn't remember. NA #2 stated			An outside facility consultant has		
	the wound looked w	orse than the last time she			in-serviced all Nurses that are working	on	
	had seen it and take	en care of the resident on			02/11/2022 on first shift (7am-7pm) on	the	
	12/15/21.				proper protocol for notifying the Attend	ing	
					Physician and Responsible Party		
		03/22 at 6:42 PM with the			concerning changes in condition and		
		DON) revealed she had been			worsening of wounds. These in-service		
	at the facility on 12/19/21. The DON stated she				included the Director of Nursing, Nurse		
	_	the NA (could not recall her			Managers, and Administrative License	d	
	, •	f the resident on 12/19/21 to			Practical Nurse as participants. The		
		and look at her wounds while			Director of Nursing will continue to		
		incontinence care. The DON the room and looked at the			in-service all staff 02/11/2022 □ 02/12/2022 to ensure that all staff have	•	
		ocks and coccyx and stated			received in-servicing on the proper	5	
		ad worsened and appeared			protocols. Any new agency staff that r	mav	
		d was tunneling. The DON			be coming to the facility in the future w		
		d a note in the provider book			be in-serviced at the start of their shift		
		e resident on her next rounds.			ensure that they are aware of the		
		the NP was at the facility 3			facility⊡s protocol. Nurses that have n	ot	
		available by phone as needed			been in-serviced by 2/12/2022 will rece		
	but said she had not	called her when she noticed			the in-service prior to working on the fl		
	the wound had wors	ened but had opted to place			-		
	a note in the provide	er book.			All CNAs working on 02/11/2022 have		
					been in-serviced by the outside facility		
		noted dated 12/22/21 written			consultant on what skin changes they		
		e #5 revealed Resident #106			need to watch for and to report these t		
		n her baseline orientation this			the unit nurse. These in-services inclu-		
	_	o respond to commands, not			the Director of Nursing as a participan		
		gue out. No grasp reflex. Not			The Director of Nursing will continue to)	
		notified for comparison to			in-service all staff 02/11/2022 □		
		rected from DON to call			02/12/2022 to ensure that all staff have	€	
		y wanted resident sent out.			received in-servicing on the proper		
		uested send to emergency			protocols. Any new agency staff that n	-	
	•	er evaluation. On call			be coming to the facility in the future w		
	_	e order to send to ED			be in-serviced at the start of their shift	το	
		nent) to rule out possible			ensure that they are aware of the	_	
		ttack (TIA)/stroke. Vital signs			facility s protocol and what to do in the		
	, 10 <i>11</i> 00, 100, 99.0, 9	7% and blood sugar 127."		- 1	event that a skin issue appears during		1

Facility ID: 923196

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7. BOILD	_		، ا	c
		345441	B. WING				/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	1 1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 021	1772022
					770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE				ASTONIA, NC 28054		
	OUR MARRY OF	ATTEMENT OF REFIGIENCIES					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Resident #106's hospital admission notes revealed she was admitted to the local hospital on 12/22/21 through the emergency department (ED) to the ICU (Intensive Care Unit). The resident was evaluated for generalized weakness and altered metal status. The resident had a decubitus ulcer that was undergoing treatment at the facility where she resided. The resident was diagnosed with acute kidney injury, hepatic encephalopathy, hypernatremia, lactic acidosis, respiratory failure, and sacral wound. The resident had a large foul-smelling decubitus ulcer that would likely require surgical evaluation and possibly debridement. They placed a urinary catheter in the ED and gave her bolus fluids, intubated her per the responsible party's (RP) request and admitted her for further management and stabilization to the critical care unit. The resident was initiated on broad-spectrum		F 580		their shift. CNAs that have not been		
					in-serviced by 2/12/2022 will receive th in-service prior to working on the floor.	e	
					MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE T ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR: The facility has designated an		
					Administrative Licensed Practical Nurs as the individual that will be completing notifications to the Attending Physician contract wound doctor, and Responsib Party concerning wounds. This Administrative Licensed Practical Nurs	ı all , le	
	antibiotics for her sepsis, and it was suspected the wound was the source of her infection. The critical care physician shared with the RP the resident needed surgical intervention for the wound but given her overall condition it was suspected she would not survive surgery, so the family member decided not to actively treat her but to extubate her, provide her with fluids, and make her comfortable. The resident died in the hospital on 12/23/21 at 4:30 PM. Her death according to the hospital records was attributed to severe sepsis.				has been in-serviced on 02/11/2022 by outside facility consultant concerning notifying the attending physician, controvation wound doctor, and Responsible Party about any changes to wounds. The Director of Nursing and two Nurse Managers were also in-serviced by the	act	
					outside facility consultant on the same topic on 02/11/2022. If the Administrative Licensed Practical Nurse is not working the time that a worsening of the wound noted, the Floor nurse will be responsible.	ve g at is ole	
	(NP) on 02/01/22 at 3 the resident on 12/10 denuded areas of she and coccyx area. Sh	th the Nurse Practitioner 3:12 PM revealed she saw //21 and she had multiple eared skin on her buttocks e stated she expected the			for notifying the Attending Physician an Responsible Party. An outside facility consultant has in-serviced all Nurses that are working 02/11/2022 on first shift (7am-7pm) on proper protocol for notifying the Attendi	on the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		Ι ,	c	
		345441	B. WING				17/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1	770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE			G	GASTONIA, NC 28054			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 580	Continued From page	e 6	F:	580				
	the wound and she w	ould have re-evaluated her			Physician and Responsible Party			
		ordered a urinary catheter			concerning changes in condition and			
		ling to the NP, had she			worsening of wounds. These in-service	es		
		d gotten worse she would			included the Director of Nursing, Nurse			
	have referred Reside	ent #106 to the wound			Managers, and Administrative License	b		
	physician.				Practical Nurse as participants. The			
					Director of Nursing will continue to			
		3/22 at 6:42 PM with the			in-service all staff 02/11/2022 □			
		ouldn't explain why the			02/12/2022 to ensure that all staff have	:		
	physician or NP had not been notified of her				received in-servicing on the proper			
	worsening decubitus ulcer but stated she				protocols. Any new agency staff that n	•		
	expected all changes especially any worsening changes to be communicated to the NP or				be coming to the facility in the future w			
	_	unicated to the NP or			be in-serviced at the start of their shift	:0		
	physician.				ensure that they are aware of the	.4		
	An intonvious on 02/01	3/22 at 7:32 PM with the			facility s protocol. Nurses that have no been in-serviced by 2/12/2022 will rece			
	Administrator reveale				the in-service prior to working on the flo			
		changes to be discussed			the in-service prior to working on the in	JOI .		
	with the NP or physic				All CNAs working on 02/11/2022 have			
	mar are rur er priyere	nam.			been in-serviced by the outside facility			
	The nursing home Ac	dministrator was notified of			consultant on what skin changes they			
		on 02/11/22 at 9:43 AM.			need to watch for and to report these to)		
	· ,				the unit nurse. These in-services include			
	Identify those recipie	nts who have suffered, or			the Director of Nursing as a participant			
	are likely to suffer, a	serious adverse outcome as			The Director of Nursing will continue to			
	a result of the noncor	mpliance:			in-service all staff 02/11/2022 □			
					02/12/2022 to ensure that all staff have	;		
		fied that the use of Staffing			received in-servicing on the proper			
		d to a breakdown in the			protocols. Any new agency staff that m			
		skin issues and notification			be coming to the facility in the future w			
		nding Physician. The use of			be in-serviced at the start of their shift	.0		
		ncy personnel resulted in a			ensure that they are aware of the			
		ssues by the agency CNAs			facility□s protocol and what to do in the	9		
		These issues led to a delay			event that a skin issue appears during			
		ound deterioration being			their shift. CNAs that have not been	_		
	evaluated by the prov	vider.			in-serviced by 2/12/2022 will receive the	е		
	The Director of Niver	ng was not awars that the			in-service prior to working on the floor.			
		ng was not aware that the			Additionally, the Director of Nursing wil	ı		

Facility ID: 923196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345441	B. WING		0:	C 2/ 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	- TITLULL
	DIA DI 405			1770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			GASTONIA, NC 28054		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	COMPLETION DATE	
F 580	Continued From page 7		F 58	30		
		und. She placed a note in the		review all wound documentation	n weekly	
	·	e Nurse Practitioner, but she		for six (6) weeks, bi-weekly for	• •	
		Nurse Practitioner by phone.		weeks, and monthly for six (6) r		
		d a note in the provider book		ensure that the Attending Physi		
	but had not notified the Nurse Practitioner by			contract wound doctor, and Res	•	
		note from Nurse #1 and the		Party have been notified of any		
		hat were placed in the		of a wound. The Director of Nur	•	
	provider book have	not been found.		document her reviews of document		
	Booldont #106 is no	longer a resident et		on a Quality Assurance form an present this form to the Quality		
		longer a resident at d therefore, no interventions		Committee for review.	Assurance	
	are needed for Resi			Committee for review.		
	are needed for Resident # 100.			HOW THE CORRECTIVE ACT	ION(S)	
	Alexandria Place ha	s identified that all residents		WILL BE MONITORED TO EN	, ,	
		be affected by this practice.		THAT its SOLUTIONS ARE AC		
				AND SUSTAINED AND HOW T		
	Specify the action th	ne entity will take to alter the		WILL BE EVALUATED FOR IT	∃S	
		ailure to prevent a serious		EFFECTIVENESS:		
	adverse outcome fro	om occurring or recurring, and				
	when the action will	be complete:				
				The Director of Nursing will revi	iew all	
		gnated an Administrative		wound documentation weekly for		
		lurse as the individual that will		weeks, bi-weekly for six (6) week		
		tifications to the Attending		monthly for six (6) months to ins		
		act wound doctor concerning		the Attending Physician, contra		
		istrative Licensed Practical		doctor, and Responsible Party		
		erviced on 02/11/2022 by an		notified of any worsening of a w		
		ultant concerning notifying the		Director of Nursing will docume		
	0. ,	and contract wound doctor to wounds. The Director of		reviews of documentation on a Assurance form and will presen	•	
		rse Managers were also		to the Quality Assurance Comm		
		tside facility consultant on the		review.	mucc ioi	
	_	/2022. If the Administrative		1011011.		
	•	lurse is not working at the		The Director of Nursing⊡s Qua	litv	
		ig of the wound is noted, the		Assurance checks will also be r		
		esponsible for notifying the		by the QAPI Committee to ensu		
	Attending Physician			solution is achieved, effective, a sustained.		
	An outside facility co	onsultant has inserviced all		SUSTAILIEU.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION		E SURVEY PLETED
		345441	B. WING _			03	C 2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 02	./1//2022
				1770	OAK HOLLOW ROAD		
ALEXAND	ORIA PLACE			GAS	STONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	shift (7am-7pm) on notifying the Attend changes in condition. These inservices in Nursing, Nurse Ma Licensed Practical Director of Nursing staff 02/11/2022 - 0 staff have received protocols. Any nev coming to the facilit inserviced at the state they are aware of the that have not been receive the inserviced by the owhat skin changes report these to the included the Director of Nur all staff 02/11/2022 staff have received protocols. Any new	rking on 02/11/2022 on first the proper protocol for ling Physician concerning on and worsening of wounds. Included the Director of magers, and Administrative Nurse as participants. The will continue to inservice all 12/12/2022 to ensure that all inservicing on the proper or agency staff that may be try in the future will be art of their shift to ensure that the facility's protocol. Nurses inserviced by 2/12/2022 will be prior to working on the floor. on 02/11/2022 have been utside facility consultant on they need to watch for and to unit nurse. These inservices or of Nursing as a participant. Issing will continue to inservice - 02/12/2022 to ensure that all inservicing on the proper or agency staff that may be	F	580	Date of Compliance is 03/11/2022.		
	coming to the facility in the future will be inserviced at the start of their shift to ensure that they are aware of the facility 's protocol and what to do in the event that a skin issue appears during their shift. CNAs that have not been inserviced by 2/12/2022 will receive the inservice prior to working on the floor. Date of alleged Immediate Jeopardy Removal: 02/13/2022. Person responsible for the implementation is the Administrator. On 02/17/22 the facility's credible allegation was						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345441	B. WING _			C 2/17/2022
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CO 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	resident interviews. education through a all nurses on the pro to the attending phy wound physician an current wounds. A the wound nurse an notifications to the p changes and change been inserviced by concerning when no all providers. The D Managers and all A included in the inserviced in the inserviced by concerning when no all providers and responsibilities for providers and responsibilities for r skin or wound chan interviewed were all their responsibilities changes. Nursing assistants of described the change expected to watch f care and who to rep their shift. The Dire continue to inservice staff on the proper p changes and what t change in residents education sheets fo working outlining the were to report the c	The facility provided an outside facility consultant to oper protocol for notifications riscian, nurse practitioner and ry changes to skin integrity or nurse had been designated as and she will be completing all providers concerning skin es in wounds. The nurse has an outside facility consultant obtifications should be made to Director of Nursing, Nurse deministrative nurses were revice by the facility consultant. It signed education sheets on notification of changes to onsible parties. Interviews wound nurse, and	F	580		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345441	B. WING _			C 02/17/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	•	0271172022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From page explain with accurate be reported and to vereported. The Director of Nursable to describe in corresponsible parties explained she or he that identified skin cowere reported, and completed. The Administrator with detail her educatified and wounds and the collaboration regarding and wounds and the collaboration regard to the residents and worsen and their materials.	ge 10 cy what skin changes were to whom they were to be sing was interviewed and was detail the new system for one ensure changes are steed timely to the providers and of the residents. The DON or designee verified the sheets changes and then verified they are progress note had been was interviewed and described on with the Nurse Practitioner all Director and Wound notification of changes in skin the progress in skin the progress in the progress in skin the progres				
	The credible allegate jeopardy removal was a removal date of 0.000 1b. An interview on Nurse #1 assigned revealed she observand described she is her bottom and cool.	ion for the immediate as validated on 02/17/22 with				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	· /	ATE SURVEY OMPLETED
		345441	B. WING			C 02/17/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	, , , , , , , , , , , , , , , , , , ,	271172022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	12/09/21, 12/12/21, said the wound had and was larger than 12/09/21. Nurse #1 Resident #106's res skin changes or the Resident #106's but A Nurse Practitione 12/10/21 revealed the for "follow up visit for breakdown." Integungositive for poor heaver described in the areas with top layer bilateral upper/postecoccyx." An interview on 02/0 Aide (NA) #2 reveal Resident #106 on 1 Director of Nursing to look at the reside wound was red with areas and there we wound. NA #2 state than the last time shof the resident on 1: An interview on 02/0 Director of Nursing at the facility on 12/1 had been asked by name) taking care of come into the room she was performing stated she went into the state of the wound she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performing stated she went into the room she was performed and t	ressing on Resident #106 on 12/15/21 and 12/18/21 and progressively gotten redder when it was first noted on stated she had not notified sponsible party (RP) of the worsening wound on tocks and coccyx. r (NP) progress note dated he resident was being seen or evaluation of buttocks imentary was noted as being aling of wounds. The wounds he notes as "multiple denuded of skin sheared off over erior thighs, buttocks, and D2/22 at 11:49 AM with Nurse ed she had taken care of 2/19/21 and had asked the (DON) to come into her room ints wound. NA #2 stated the isome bleeding in some re areas of black on the ed the wound looked worse he had seen it and taken care	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345441	B. WING _			C)2/17/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	as though the wound the DON stated she in #106's responsible prochanges and stated she had not notified it said she should have wound had worsened. A phone interview on #106's family member responsible party (Ristated she had visite on 12/15/21 and was any skin breakdown. Not aware of Resider decubitus ulcer until shospital emergency or resident had a stage tunneling and severe indicated she should apprised of the resident progress of the worsened she company to the worsened she worsened	and worsened and appeared was tunneling. Additionally, had not notified Resident arty (RP) of the wound she could not remember why he RP of the changes but a notified her when the d. 02/01/22 with Resident ar revealed she was the P) for the resident. The RP d the resident at the facility not told the resident had The RP indicated she was at #106's worsening she was notified by the department physician that the IV decubitus ulcer with sepsis. The RP further have been notified and kept ent's wound and treatment	F 5	80			
F 638 SS=E	notified of any and al	ested family members to be I changes in residents. Least Every 3 Months	F 6	38		3/11/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345441	B. WING		0	C 2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	271172022
				1770 OAK HOLLOW ROAD		
ALEXAND	ORIA PLACE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 638	CFR(s): 483.20(c)		F 63	8		
	and approved by CM once every 3 months	s a resident using the ument specified by the State S not less frequently than				
	Based on record rev facility failed to comp Set (MDS) assessme timeframes as specif Assessment Instrume	iew and staff interviews, the lete quarterly Minimum Data ents within the regulatory ied in the Resident ent (RAI) manual for 3 of 14 viewed (Residents #20, #23		" F-638: CORRECTIVE ACTION(S) THAT BE ACCOMPLISHED FOR THOS RESIDENTS FOUND TO HAVE E AFFECTED BY THE DEFICIENT PRACTICE:	SE BEEN	
	The findings included 1.Resident #20 was a	l: admitted to the facility on		Quarterly Minimum Data Set assessments for residents #20, #. #24 have been completed by the Minimum Data Set Coordinator.		
	A review of Resident revealed the most re- assessment was a qu	uarterly dated 10/14/21.		HOW OTHER RESIDENTS HAVE IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED E SAME DEFICIENT PRACTICE AI CORRECTIVE ACTION(S) THAT	BY THE ND THE	
	on 2/3/22 at 3:51 PM no further MDS asse MDS coordinator furt pulled from her MDS complete tasks for th able to complete mul were due in January stated it was expecte MDS assessments co	ed with the MDS Coordinator revealed Resident #20 had ssments since October. The her revealed she had been duties to assist staff and e facility and had not been tiple MDS assessments that The MDS coordinator of for her to have resident completed every 90 days.		Any resident has the potential to be affected by this practice. All reside have been reviewed to ensure the Quarterly Minimum Data Set Assessments have been complete accordance with the time frames a specified in the Resident Assessment manual. Any assessment were found to not be completed in	ents at current ed in as nent ents that	
		ed with the Director of 3/22 at 6:32 PM revealed		required time frame have been completed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345441	B. WING			C / 17/2022	
NAME OF P	ROVIDER OR SUPPLIER	0.0111		STREET ADDRESS, CITY, STATE, ZIP CODE	02	11/12022	
				1770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE			GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 638	Continued From page	e 14	F 638	3			
	missed quarterly MD	at Resident #20 had a S. The DON further revealed esidents to have an MDS days.		MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MAI			
	An interview conducted with the Administrator on 2/3/22 at 7:26 PM revealed she was not aware that Resident #20's MDS had not been completed. The Administrator further revealed the MDS Coordinator had been pulled to assist with the facility outbreak but expected for residents MDS assessments to be completed in a timely manner.			ENSURE THE DEFICIENT PRAC DOES NOT RECUR: The facility Minimum Data Set	TICE		
				Coordinator was in-serviced on 3/0 by an facility Consultant Minimum Set Nurse on the importance of completing quarterly Minimum Data The facility Minimum Data Set Coordinator will use a calendar to	Data ta Sets.		
	2. Resident #23 was 7/15/2021.	admitted to the facility on		when a resident⊡s Minimum Data assessment is due and will presen calendar to the facility Administrato	nt that		
	record revealed the n	•		start of each month. The facility Administrator will then review all M Data Set Assessments to ensure t are completed timely in accordance the Resident Assessment Instrume manual. The Administrator will rec- results of her review on a Quality	finimum hat they se with ent		
	Interview with the MDS Coordinator on 2/2/2022 at 3:34 PM revealed she had not completed an MDS for Resident #23 since October. The MDS Coordinator disclosed she had been on leave for several weeks. The MDS Coordinator indicated following her return to work, she had been			Assurance Form.	N(S)		
	working in direct residual performing other facili several months. The	dent care as well as ity duties for the past MDS Coordinator stated sponsible for completing		HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSUITHAT ITS SOLUTIONS ARE ACHIE AND SUSTAINED AND HOW THE WILL BE EVALUATED FOR IT SEFFECTIVENESS:	RE EVED E PLAN		
		ector of Nursing (DON) on revealed she was aware		The facility Administrator will then all Minimum Data Set Assessment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345441	B. WING			C 02/17/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		5211112022
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 638	while resident care cathe requirements for a DON indicated her exwere completed accooutlined in the Reside 3. Resident #24 was 5/2/17. Review of Resident #record revealed the massessment was code an ARD of 10/23/21. There were no other progress. An interview with the at 3:53 PM revealed assessments that she stated she hadn't had quarterly MDS but it was more stated she was mare sidents than paper. An interview with the on 2/3/22 at 6:22 PM have MDS assessments that past residents testing posithe COVID-19 unit. To surprising that the ME	done. The DON stated ame first, she understood completing the MDS. The spectation was that MDS rding to the timeframes ent Assessment Instrument. admitted to the facility on 24's electronic medical nost recent MDS ed as a quarterly MDS with MDS assessments in MDS Coordinator on 2/3/22 she was aware of MDS e hadn't completed yet. She time to start Resident #24's was in her calendar. The ted she had been busy dents in and out of facility had been in outbreak. Hore concerned about the	F 63	ensure that they are completed accordance with the Resident Assessment Instrument manual Administrator will record the review on a Quality Assurance will present the results to the CASSURANCE Committee for review results will also be presented to Committee for review to ensure solution is achieved, sustained effective. Date of Compliance is 03/11/26	al. The sults of her Form and Quality ew. The to the QAPI that the , and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345441	B. WING				C 17/2022
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD GASTONIA, NC 28054	1 021	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640 F 640 SS=E	CFR(s): 483.20(f)(1)-1- §483.20(f) Automated requirement- §483.20(f)(1) Encodir a facility completes a facility must encode the each resident in the facility Admission assessment (ii) Aldmission assessment (iii) Significant change (iv) Quarterly review at (v) A subset of items reentry, discharge, arrowing Background (face is no admission assessment after a facility comple a facility must be capacted to the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transmant days after a facility assessment, a facility encoded, accurate, at the CMS System, inclinical inclinical contained in the MDS (i) Admission assessment (ii) Admission assessment (iii) Significant change (iiii) Significant change (iiiii) Significant change (iiii) Significant (iiiii) Significant (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	g Resident Assessments (4) d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. upon a resident's transfer, and deathsheet) information, if there is sment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to uts and data dictionaries, dardized edits defined by ittal requirements. Within a complete a resident's must electronically transmit and complete MDS data to luding the following: nent. int. e in status assessment. tion of prior full assessment.		640 640			3/11/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		C 02/17/2022
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	02/1//2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 640	reentry, discharge, a (viii) Background (fainitial transmission of does not have an accession of several services of transmit data in the for a State which haby CMS, in the form approved by CMS. This REQUIREMENT by: Based on record refacility failed to compute Set (MDS) assingulatory timeframe Resident Assessment for 5 of 19 sampled (Residents #9, #1, #The findings include 1. Resident #9 was 5/9/20. Review of Resident record revealed the assessment was concessed assessment Referent The MDS assessment Referent The MDS assessments that shad transmitted yet. She complete Resident #8 complete	is upon a resident's transfer, and death. ce-sheet) information, for an if MDS data on resident that imission assessment. Dormat. The facility must format specified by CMS or, is an alternate RAI approved at specified by the State and improved at specified in the improved in t	F 64	" F-640: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Minimum Data Set assessments residents #9, #1, #7, #10, and #11 have been completed and transmitted. HOW OTHER RESIDENTS HAVE BE IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY T SAME DEFICIENT PRACTICE AND T CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident has the potential to be affected by this practice. All residents have been reviewed by the facility Administrator to ensure that Minimum Data Set Assessments have been completed and transmitted in accorda with the time frames as specified in the	for ve EN HE THE 'E

PRINTED: 03/21/2022 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
345441 B. WING	02/17/2022
NAME OF PROVIDER OR SUPPLIER ALEXANDRIA PLACE STREET ADDRESS, CITY, STATE, ZI 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AT AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE
F 640 Continued From page 18 since the ARD date. The MDS Coordinator stated she hadn't had time because she had been busy helping move the residents in and out of quarantine since the facility had been in outbreak. An interview with the Director of Nursing (DON) on 2/3/22 at 6:22 PM revealed she expected to have MDS assessments completed timely. The DON stated the past month had been crazy with residents testing positive and moving residents to the COVID-19 unit. The DON stated it was not surprising that the MDS assessments didn't get completed and transmitted on time, but it was not acceptable. 2. Resident #1 was admitted to the facility on 1/5/19. Review of Resident #1's electronic medical record revealed the most recent MDS assessment was coded as a quarterly with an ARD of 1/1/22. The MDS assessment had a status of 'open." An interview with the MDS Coordinator on 2/3/22 at 3:53 PM revealed she was aware of MDS assessments that she hadn't completed and transmitted yet. She knew she had 14 days to complete Resident #1's quarterly MDS assessment and that it had been over 14 days since the ARD date. The MDS Coordinator stated she hadn't bad time because she had been busy helping move the residents in and out of quarantine since the facility had been in outbreak. An interview with the Director of Nursing (DON) on 2/3/22 at 6:22 PM revealed she expected to WILL BE EVALUATED F	were found to not mitted in the mitted in the mitted in the me been completed EYSTEMIC TO BE MADE TO ENT PRACTICE Inta Set miced by the facility manual and set as mitted timely in sident manual. The manual and the

Facility ID: 923196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		02/	7/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	02/	1772022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 640	DON stated the past residents testing posithe COVID-19 unit. The Surprising that the MI completed and transmacceptable. 3. Resident #7 was a 01/29/20. Resident #7 's electrous electrou	ents completed timely. The month had been crazy with litive and moving residents to The DON stated it was not DS assessments didn't get mitted on time, but it was not dmitted to the facility on conic medical record cent MDS assessment was with an ARD of 01/05/22. In thad a status of "open." MDS Coordinator on revealed she was aware of last she had not completed be knew she had 14 days to 7's annual MDS it had been over 14 days. The MDS Coordinator and time because she had lying COVID-19 positive of the COVID unit since the lutbreak. Director of Nursing (DON) PM revealed she expected to lents completed timely. The month had been crazy with litive for COVID-19 and the COVID unit. The DON orising MDS assessments and transmitted on time,	F 640	EFFECTIVENESS: The facility Administrator will then all Minimum Data Set Assessmer ensure that they are completed a transmitted timely in accordance Resident Assessment Instrument The Administrator will record the her review on a Quality Assurance and will present the results to the Assurance Committee for review. results will also be presented to the Committee for review to ensure the solution is achieved, sustained, a effective. Date of compliance is 03/11/2022	nts to nd with the manual. results of e Form Quality . The he QAPI hat the nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345441	B. WING_			C 02/17/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	02/17/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 640	Resident #10" s ele revealed the most coded as a quarter 01/07/22. The MD "open." An interview with the 02/03/22 at 3:53 Ple MDS assessments and transmitted. So complete Resident assessment and the since the ARD date stated she had not been assisting in more residents in and out facility had been in An interview with the on 02/03/22 at 6:22 have MDS assessment on	ectronic medical record (EMR) recent MDS assessment was ly with an ARD date of S assessment had a status of that she had not completed he knew she had 14 days to #7's annual MDS at it had been over 14 days at it had been over 14 days. The MDS Coordinator had time because she had avoving COVID-19 positive to fithe COVID unit since the outbreak. The Director of Nursing (DON) PM revealed she expected to ments completed timely. The st month had been crazy with one that coving MDS assessments ed and transmitted on time,	F 64	40		
	5. Resident #11 w. 12/17/2019.	as admitted to the facility on				
	quarterly assessme	t #11's MDS revealed a ent dated 1/7/2022 had been npleted or transmitted.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED	
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NAME OF PE	ROVIDER OR SUPPLIER	345441	B. WING _	ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2022
	RIA PLACE			17	70 OAK HOLLOW ROAD ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 640	at 3:56 PM revealed	e 21 PS Coordinator on 2/3/2022 She had been working in and had not had time to	F	640			
	complete MDS. The M had a worksheet of M time to enter into the Coordinator verbalize	MDS Coordinator stated she IDS that she had not had system. The MDS d her responsibility was to sessments and transmit					
	Interview with the Director of Nursing on 2/3/2022 at 6:26 PM revealed she expected MDS to be completed and transmitted according to the required schedules.						
F 656 SS=E	Develop/Implement C CFR(s): 483.21(b)(1)	comprehensive Care Plan	F (656			3/11/22
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483.	cility must develop and bensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ided in the comprehensive aprehensive care plan must 19 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		0.	C 2/17/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		2/1//2022	
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F 656	rehabilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes. (B) The resident's profuture discharge. Fact whether the resident's community was asselocal contact agencie entities, for this purpo (C) Discharge plans is plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on record revisacility failed to devel comprehensive care of 4 resident #31); applies stockings (Resident #23); and stockings included 1.a. Resident #31 was reside	ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. The the resident and the tive(s)-als for admission and eference and potential for editities must document as desire to return to the ssed and any referrals to and/or other appropriate ose. In the comprehensive care in accordance with the hain paragraph (c) of this are is not met as evidenced item and interventions for 4 areas of wound care cation of anti-embolism 431, #11); use of oxygen smoking (Resident #30).	F 6	" F-656: CORRECTIVE ACTION(S) T BE ACCOMPLISHED FOR T RESIDENTS FOUND TO HA AFFECTED BY THE DEFICI PRACTICE: The noted interventions for re #11, #23, and #30 have beer their respective comprehensi and the new care plans have implemented. HOW OTHER RESIDENTS	HOSE AVE BEEN ENT esidents #31, n added to ive care plans been		
	revealed the following	t31's Physician orders g: y antiembolism stockings to		IDENTIFIED FOR HAVING T POTENTIAL TO BE AFFECT SAME DEFICIENT PRACTIC	THE TED BY THE		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
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NAME OF D	ROVIDER OR SUPPLIER	343441		٥.	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2022
NAIVIE OF PI	ROVIDER OR SUPPLIER						
ALEXAND	RIA PLACE				770 OAK HOLLOW ROAD		
				G	GASTONIA, NC 28054		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	6 Continued From page 23		F 6	656			
	bilateral lower extrem remove at bedtime.	nities every morning and			CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN:	E	
	care plan or intervent antiembolism stockin An interview with the 2/3/2022 at 3:56 PM care plans had not be Coordinator indicated work in direct resider care came first, but s responsibility to compupdates every 90 day An interview with the	dated 11/8/2021 revealed no tions related to application of gs. MDS Coordinator on revealed she was aware een updated. The MDS d she had been pulled to at care. She stated resident he acknowledged it was her polete care plan reviews and ys.			Any resident has the potential to be affected by this practice. All resident caplans have been reviewed by the facilit Administrator to ensure that comprehensive care plans have been developed and implemented. Any care plans that were found to not be comprehensive have been updated an implemented. MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TENSURE THE DEFICIENT PRACTICE DOES NOT RECUR:	d O E	
	conditions related to included in the care p	s admitted to the facility on ses of coronary artery			The facility Consultant Minimum Data S Nurse in-serviced the facility Minimum Data Set Coordinator on 03/09/2022 about the requirement of developing, completing, and implementing comprehensive care plans for residents. The facility Minimum Data Set Coordinator will submit completed care	S.	
	revealed the following 1/17/2022 - appl lesions twice daily. Review of Resident # 5/6/2021 and last upocare plan or intervent of lesions on the resident.	y antibacterial cream to nasal #31's care plan dated dated 11/8/2021 revealed no tions related to the treatment			plans to the facility Administrator for review so that they can be assessed to ensure that they are comprehensive before being implemented on the unit. The Administrator will review care plan for six (6) months to ensure that the deficient practice does not recur. The facility Administrator will document the results of her review on a Quality Assurance Form and will present the results to the facility Quality Assurance	s	
	at 3:56 PM revealed	she was aware care plans d. The MDS Coordinator			Committee for review.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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				1770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE			GASTONIA, NC 28054			
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F 656	Continued From pag		F 6	56			
	resident care. She sirst, but she acknow responsibility to comupdates every 90 da Interview with the Diat 6:26 PM revealed related to active treacare plan. 2. Resident #11 was 12/17/2019 with diag disease and chronic Review of Resident revealed the followin 4/16/2020 - app	plete care plan reviews and ys. rector of Nursing on 2/3/2022 she expected conditions tments to be included in the s admitted to the facility on gnoses of coronary artery congestive heart failure. #11's Physician orders ag: ly antiembolism stockings in the off in the evening. Elevate		HOW THE CORRECTIVE WILL BE MONITORED TO THAT ITS SOLUTIONS AR AND SUSTAINED AND H WILL BE EVALUATED FO EFFECTIVENESS: The facility Administrator of plans to ensure that they comprehensive before be on the unit. The facility Addocument the results of h Quality Assurance Form at the results to the facility Committee for review. The be presented to the QAPI review to ensure that the achieved, sustained, and	O ENSURE RE ACHIEVED HOW THE PLAN OR IT S will review care are sing implemented dministrator will her review on a land will present Quality Assurance he results will also I Committee for solution is		
	7/8/2021and last revalue a care plan focus on included bilateral low of diuretics. The carantiembolism stockir extremities due to confirm the material of the confirmation of the confirma	plete care plan reviews and		Date of compliance is 03/	11/2022		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345441	B. WING _			C 02/17/2022
	ROVIDER OR SUPPLIER	1 237.0		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	1	02/11/2022
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F 656	related to active trea care plan. 3. Resident #23 was	she expected conditions atments to be included in the sadmitted to the facility on	F 6	56		
	_	noses of chronic obstructive (COPD) requiring the use of				
	revealed the followir	#23's Physician orders ng: gen via nasal cannula at 2				
	7/18/2021 and last r	#23's care plan dated eviewed 10/17/2021 revealed or interventions for COPD or				
	at 3:56 PM revealed had not been update indicated she had be resident care. She s first, but she acknow	plete care plan reviews and				
	at 6:26 PM revealed	rector of Nursing on 2/3/2022 she expected conditions atments to be included in the				
	4.Resident #30 was 3/9/21 with diagnose hypertension and hy					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		7 22 2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 656	Continued From pa	age 26	F 65	6		
	Data Set (MDS) da resident was cogniwith no assistance living (ADL). Review of Residen revealed there was that addressed small revealed there was that addressed small revealed there was a safe smoker. The evaluation furt for further details for An observation was a m revealed Resid	t #30's Safe Smoking /26/22 revealed Resident #30 that required no supervision. her revealed to see care plan				
	on 2/2/22 at 3:30 P assessment was or 1/26/22. The care p revealed Resident that addressed smic coordinator stated at #30 was a smoker address Resident # An interview condu Nursing (DON) on a Resident #30 was at was not aware that planned for smoking	icted with care plan coordinator I'M revealed a smoking completed on Resident #30 on colan coordinator further #30 did not have a care plan coking. The care plan she was not aware Resident but would create a care plan to #30's smoking. Icted with the Director of 2/3/22 at 7:15 PM revealed an unsupervised smoker but It Resident #30 was not care leg. The DON further revealed lesident #30's care plan to be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD ASTONIA, NC 28054	, , ,		
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F 656	2/3/22 at 7:25 PM rev Resident #30's care p smoking. The Admini MDS Coordinator who been pulled to assist	ed with the Administrator on realed she was not aware plan did not address strator further revealed the completed care plans had with the facility outbreak but	F	656				
F 658 SS=D	smoking. Services Provided Me CFR(s): 483.21(b)(3) §483.21(b)(3) Compr The services provided as outlined by the compust- (i) Meet professional	ehensive Care Plans d or arranged by the facility, nprehensive care plan,	F	658			3/11/22	
	interviews, the facility order to apply antiem residents (Residents follow a physician ord 1 of 1 resident (Resident professional standard). The findings included 1. Resident #11 was 12/17/2019 with diagratic disease and chronic of a. Review of Resider revealed the following 4/16/2020 - apply	admitted to the facility on noses of coronary artery congestive heart failure. at #11's Physician orders g: y antiembolism stockings in off in the evening. Elevate			" F-658: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The order for TED hose has been discontinued for Resident #11 and Resident #31 due to resident non-compliance with wearing of the TE hose. Resident #31 did not have an ord for daily weights, but Resident #11 did. Resident #11 sorder for daily weights has been changed to weekly weights. A order changes have been done after discussion with the facility Attending Physician.	D der		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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				1770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE			GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	10/7/2021 revealed herequired limited assist dressing and personal was not coded for regarders. Review of Resident # 10/7/2021 revealed a description that increase extremity edema and plan did not include ustockings or elevation.	erly Minimum Data Set dated ne was cognitively intact and stance of 1 person for al hygiene. Resident #11 section of care. #11's care plan reviewed on a care plan focus on skin with luded bilateral lower I use of diuretics. The care use of antiembolism of the lower extremities	F 65	HOW OTHER RESIDENTS HAD IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTE SAME DEFICIENT PRACTICE CORRECTIVE ACTION(S) THE BEEN OR WILL BE TAKEN: Any resident has the potential affected by this practice. All resident has have been audited by the Administrative Nurse and any inoted to have orders for TED in Daily weights have been check.	E D BY THE E AND THE AT HAVE to be sident the facility resident those and ked to		
	due to congestive her Observation of Resident 10:12 AM while sittin bilateral lower extrem by excess fluid trapp Resident #11 did not stockings on. Review of Resident # Administration Record through 2/3/2022 revistocking application I completed every day Observation of Resident	art failure. lent #11 on 1/31/2022 at g in his wheelchair, revealed nity edema (swelling caused ed in body tissues). have antiembolism #11's Treatment rd (TAR) dated 1/31/2022 ealed the antiembolism had been signed off as . lent #11 on 2/1/2022 at 12:05 lying in bed and was not		ensure that TED hose and weiger are being followed as written. Administrative Nurse has in-see facility staff on the importance TED hose and of obtaining ord weights. The Director of Nursing emailed all staffing agencies the contracts with for temporary starequested that all nursing staff for Alexandria Place be in-servimportance of applying TED hose obtaining ordered weights. The agencies have been instructed in-service their staff and have the sign that they have been in-servithis topic prior to coming to the work. The staffing agencies are the in-services and correspondent.	ght orders The facility rviced all of applying ered ng has he facility affing and scheduled riced on the he staffing to cheir staff rviced on facility to he emailing ling		
	AM revealed the resi He was not wearing this feet and ankles we Interview with the Nu	dent #11 on 2/2/2022 at 9:43 dent sitting in his wheelchair. antiembolism stockings and vere edematous. Trespective results of the consequences of the consequences		signature pages back to the far show that their staff have been in-serviced. MEASURES AND/OR SYSTE! CHANGES MADE OR TO BE ENSURE THE DEFICIENT PR DOES NOT RECUR:	MIC MADE TO		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345441	B. WING _				C 17/2022
	ROVIDER OR SUPPLIER		•	17	REET ADDRESS, CITY, STATE, ZIP CODE 70 OAK HOLLOW ROAD ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	was increased edem expected her orders. Telephone interview was 2:59 PM revealed her to care for Resident was not aware Resident was tockings and he musapplication by mistak Interview with Nurse 3:03 PM revealed Not applying resident's stated NAs did not sistockings, but Nurse application and sign as tockings, but Nurse application and sign application and sign as tockings, but Nurse application and sign applicatio	nbolism stockings as ordered a. The NP stated she to be followed. with Nurse #6 on 2/3/2022 at was conssistently assigned #11. Nurse #6 stated he was #11 wore antiembolism st have signed for the e. Aide (NA) #3 on 2/3/2022 at as were responsible for tockings after bathing. NA #3 gn for application of s were to verify stocking off for them. NA #3 stated sident #11's stockings NA #3 indicated Nurses ent refused care, but she did informing the Nurse of the	F	658	The facility Administrative Nurse and Medical Records Nurse will conduct audits for use of TED hose and ordered weights daily for six (6) weeks, then weekly for six (6) weeks, and then monthly thereafter to ensure that TED hose and weights are being applied/obtained as ordered. The Administrative Nurse will record the results of these audits on a Quality Assurance form and will present the forto the Quality Assurance Committee for review. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAWILL BE EVALUATED FOR IT SEFFECTIVENESS:	rm r	
	at 6:26 PM revealed completed as written treatments to be inclu DON stated she expeapplication of stockin b. Review of Reside revealed the following 7/22/2021 - obtain Review of the facility Resident #11 had da	she expected orders to be and active diagnoses with uded in the care plan. The ected Nurses to verify gs prior to signing the TAR. Int #11's Physician orders g: in weight daily weight notebook revealed ily weights recorded for 27/2021. No further daily			Records Nurse will record the results of these audits on a Quality Assurance for and will present the form to the Quality Assurance Committee for review. The Quality Assurance form will also be presented to the QAPI Committee for review to ensure that the solutions are achieved and sustained. Date of compliance is 03/11/2022.	rm	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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ALEXAND	RIA PLACE				1770 OAK HOLLOW ROAD GASTONIA, NC 28054		
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F 658	change history reveal have a documented w 9/2/2021, 9/7/2021, 9 9/21/2021, 10/8/2021 through 10/13/2021, 11/16/2021, 11/16/2021, 11/16/2021 through 12/24/2021, 11/13/2022, 1/5/2022, 1/3/2022, 1/5/2022, 1/13/2022, 1/15/2022 that were obtained rebetween 292.4 pound Interview with the Nur 2/3/2022 at 11:36 AM of not weighing a CHI that weights were use medications. The NP 3-pound a week weig diuretics (medications extra fluid and salts). expected her orders to Interview with Medica 02/03/22 at 2:54 PM weights in the facility. Weights were weekly, daily. MA#1 stated sl #11 was to be weighted was updated on new Interview with the Directions due to the second state of the second suppossible orders was possible orders were weekly was possible orders was possible orders were weekly of the second suppossible orders was possible orders were weekly of the second suppossible orders was possible orders were weekly of the second suppossible orders was possible orders were weekly of the second suppossible orders were second suppossible orders were second	entl's electronic weight led Resident #11 did not weight for 7/24/2021, /8/2021, 9/20/2021, , 10/9/2021, 10/15/2021, 10/15/2021, 11/15/2021, 11/15/2021, 11/15/2021, 12/4/2021, 12/27/2021, 12/20/2021, 12/27/2021, 12/28/2021, /7/2022, 1/12/2022, , 1/18/2022 through and 1/28/2022. Weights wealed weight fluctuations is and 339 pounds. Trese Practitioner (NP) on a revealed the consequences of resident as ordered was red to adjust diuretic of indicated she used a ht difference to adjust is that help the body expel of the NP stated she to be followed.	F	658			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, Z 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	ZIP CODE	<u> </u>	
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F 658	Continued From pag	ie 31 on from physician or NP	F 6	658			
		cussed with the provider and					
		admitted to the facility on oses of coronary artery nsion.					
	revealed the followin 5/14/2020 - app	#31's Physician's orders og: ly antiembolism stockings to nities every morning and					
	Set (MDS) dated 11/ moderately cognitive required extensive a	#31's annual Minimum Data 82021 revealed she was ely impaired. Resident #31 ssistance of 1 person for tally dependent on 1 person					
	11/8/2021 revealed related to application	#31's care plan dated no care plan or interventions n of antiembolism stockings. o care plan for rejection of					
	2:24 PM revealed th	dent #31 on 1/31/2022 at e resident seated in a white socks, slip-on shoes n stockings.					
	through 2/3/2022 rev	#31's Treatment rd (TAR) for 1/31/2022 realed the antiembolism n had been signed off as					
	Interview with the Nu	urse #3 on 2/1/2022 at 10:55					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345441	B. WING				C 17/2022
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	1 021	11/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	the facility including to she was aware of the Resident #31's application stockings. Nurse #3 apply Resident #31's was the responsibility. Observation of Reside PM revealed the resident was not stockings. Observation of Reside AM revealed her sitting pink and white socks stockings. Telephone interview (NP) on 2/3/2022 at not recall Resident #3 antiembolism stocking. Telephone interview value 2:59 PM revealed her to care for Resident #3 antiembolism stockings. Nurse #6 application of the stockings and Nurses were resigning for the application of apply Resident #3 agitated the resident #3 agitated the resident #3 agitated the resident #3 application of the application of apply Resident #3 agitated the resident #3 agitated the resident #3 agitated the resident #3 agitated the resident #4 agitated the resident	formed a variety of tasks in reatments. Nurse #3 stated a treatment order for cation of antiembolism disclosed that she did not antiembolism stockings as it of the hall Nurse. Lent #31 on 2/2/2022 at 3:13 dent sitting in her wheelchair nite socks and shoes on. Wearing antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and no antiembolism Lent #31 on 2/3/2022 at 8:53 and in her wheelchair wearing and 8:50 and	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658 F 686 SS=J	3:21 PM revealed Re times. Nurse #7 state #31 for cooperation in completion of care. Interview with the Director of care. Interview with the Dir	with Nurse #7 on 2/3/2022 at sident #31 refused care at ed re-approaching Resident most often resulted in ector of Nursing (DON) on revealed she expected ed as written and active ments to be included in the stated she expected Nurses of stockings prior to signing event/Heal Pressure Ulcer (i)(ii) prity re ulcers.		686		3/11/22	
	resident, the facility m (i) A resident receives professional standard pressure ulcers and of ulcers unless the individemonstrates that the (ii) A resident with prenecessary treatment with professional star promote healing, previous REQUIREMENT by: Based on observation Nurse Practitioner, ar interviews, the facility	s care, consistent with Is of practice, to prevent Iloes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent Iloping. is not met as evidenced ins, record reviews, staff,		" F-686: CORRECTIVE ACTION(S) THAT WIL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		02/17/2022	,
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	OZ/11/ZOZZ	
				1770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE COMPLET	(X5) COMPLETION DATE
				DEFICIENCY)		
F 686	Continued From pag	ge 34	F 68	6		
		llcer, and ensure treatments Nurse Practitioner in		AFFECTED BY THE DEFICIEN PRACTICE:	Т	
	accordance with the	treatment plan (Resident				
	,	06 was hospitalized on		Resident #106 is no longer a re		
	12/22/21 with a stag			Alexandria Place and therefore,		
		nd tissue loss) with tunneling ue destruction under the skin		interventions are needed for Re 106.	sident#	
	, , ,	also failed to provide		100.		
		as ordered by the physician				
		s was for 2 of 3 residents				
		e ulcers (Residents #106 and				
	#44).			HOW OTHER RESIDENTS HA		
		h 40/40/04 h 4h -		IDENTIFIED FOR HAVING THE		
		began on 12/19/21 when the de the necessary care and		POTENTIAL TO BE AFFECTED SAME DEFICIENT PRACTICE		
		are and are that deteriorated in		CORRECTIVE ACTION(S) THA		
		ediate jeopardy was removed		BEEN OR WILL BE TAKEN:	NI TIAVE	
		e facility implemented an		BEEN ON WILL BE WINCH		
		allegation for Immediate		Alexandria Place has identified	that any	
		The facility remains out of		residents have the potential to b	-	
	compliance at a lowe	er scope and severity level of		by this practice.		
	,	with the potential for more				
	than minimal harm th			The facility has designated an		
	, , ,	education and monitoring		Administrative Licensed Practic		
		ce are effective. Example #2		as the individual that will be con		
	was cited at a scope	and severity level of "D".		skin assessments, wound dress changes, and notifications to the	_	
	The findings include	d:		Physician. This Administrative L	-	
	The infairigs include	u.		Practical Nurse has been in-ser		
	1. Resident #106 wa	s admitted to the facility on		02/11/2022 and assisted the Dir		
	09/21/13 with diagno	_		Nursing and two Nurse Manage	rs in	
		ure, peripheral vascular		completing skin audits and orde		
	_	etes mellitus, dementia, and		for all residents on 02/11/2022.		
	chronic pain syndror			facility consultant conducted the		
	Pesident #106's aug	urterly Minimum Data Sat		of the Administrative Licensed F Nurse and also in-serviced the		
		rterly Minimum Data Set aled she was moderately		Nursing and two Nurse Manage		
		and required extensive		The results of the audit showed		
		with bed mobility, transfers		residents receiving wound treat		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		C	
NAME OF D	201/1050 00 01 1001 150	343441		27DEET ADDDESS OFF	02/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AI FXAND	RIA PLACE		'	1770 OAK HOLLOW ROAD		
ALLAAND	MAT EAGE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.75	
F 686	Continued From page	e 35	F 686	8		
	and toileting. The MD	OS further revealed Resident		currently receiving the correct treatme	nt I	
	#106 was always inco			and that no new skin issues exist.		
	_	r developing pressure ulcers				
		ent. The MDS indicated		The facility has also in-serviced all sta	ff	
		pressure reducing device on		that are working on 02/11/2022 on first		
		no documented behaviors		shift (7am-7pm) on the proper protoco		
	reflected in the MDS.			notifying the Unit Nurse, Administrative		
				Licensed Practical Nurse, Nurse		
	Resident #106's care	plan dated 10/07/21		Managers, or Director of Nursing of an	v	
		re for pressure ulcers. The		skin breakdown or skin integrity issues		
		dent #106 had diagnoses of		The unit nurses have been in-serviced		
		dementia, congestive heart		the proper way to assess, document, a	and	
	failure and lymphedema. She was noted with a			notify the physician of any skin issues		
	history of pressure uld	cers. She was incontinent of		may be brought to their attention by th	e	
	bladder and bowel. S	Staff assists with toileting and		CNAs. CNAs were in-serviced on wha	t to	
	peri care frequently a	nd as needed (prn). She		do to prevent pressure ulcers, notifying	g	
	required extensive to	total assistance with		the nurse of resident refusals of turning	g	
		g (ADL) and transfers.		and repositioning, notifying nurses of		
		t risk for skin breakdown.		resident refusals to get out of bed, and		
		uded provide supplemental		what skin changes they need to watch	for	
		onitor labs as ordered,		and to report these to the unit nurse.		
	·	ents per facility protocol,		These in-services were conducted by		
		tional intake, maintain		outside facility consultant and included		
	· •	attress to bed, provide		Director of Nursing as a participant. The	ne	
		quently and as needed,		Director of Nursing will continue to		
	•	ing morning care and		in-service all staff 02/11/2022		
	treatments as ordered			02/12/2022 to ensure that all staff have	9	
	documented care pla	n for refusal of care.		received in-servicing on the proper		
	Posidont #106la aldia	202020mont dated 10/17/21		protocols. Any new agency staff that n	-	
		assessment dated 10/17/21		be coming to the facility in the future w		
	•	s with skin, skin warm, dry eview of the record revealed		be in-serviced at the start of their shift	10	
		e of any skin assessments		ensure that they are aware of the facility s protocol and what to do in the		
		nd dated from 10/18/21		event that a skin issue appears during		
	through 12/07/21.	iu dated IIOIII 10/10/21		their shift.		
	unougn 12/01/21.			uicii Siiiit.		
	Resident #106's skip	assessment dated 12/08/21		The Nurse Practitioner has been		
		would not let nurse check		in-serviced by the facility Administrato	r on	
		States she had no open		the proper protocol for writing orders a		
	S Classical Violbic.	Timing one had no open		and proper protector writing orders a		

Facility ID: 923196

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	, ,	TE SURVEY MPLETED
		345441	B. WING			С
NAME OF D		345441	B. WING		•	2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ALEXAND	RIA PLACE			1770 OAK HOLLOW ROAD		
,,,,,,,,				GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Continued From page	e 36	F 68	36		
	skin visible." The not who had attempted the were no progress not indicated Nurse #2 at assessment later that Resident #106's nurse 12/09/21 at 4:33 AM, evaluation completed nurse check skin that she has no open area issues/abnormalities during nursing evaluations to skill stable, no s/s distress scheduled pain media.			notifying the Nursing Staff of a in orders. She has also been that she is to follow all wound weekly basis or more often if is to report off to the Director and Administrator any change or wound orders. This report in writing. The facility Administ established a new protocol with wound stage II or greater will automatically be referred to the Care Physician. The Administ contacted the Wound Care Plattending Physician, and Atter Practitioner on 02/11/2022 and informed each of them of the writing orders and notifying the change in orders.	informed s on a needed and of Nursing es in wounds will be made strator has hereby any ne Wound trator hysician, the ending Nurse id has protocol for	
	An interview on 02/02/22 at 11:41 AM with Nurse Aide (NA) #1 revealed she had taken care of Resident #106 on 12/09/21 and reported to Nurse #2 that her skin was red on her buttocks and coccyx area, and she had several areas that looked raw and were red. She stated there were areas on the back of her legs and her bottom and coccyx area. NA #1 stated this was the first day she had noticed her buttocks being red. An interview on 02/03/22 at 5:30 PM with Nurse #1 assigned to Resident #106 on 12/09/21 revealed she had been called into the shower room by the Nurse Aide (could not recall her name) caring for the resident on 12/09/21 to look at her bottom. Nurse #1 stated she went into the shower room to see Resident #106's bottom and described the resident was moaning and groaning and said she had several different areas on her bottom and coccyx with one area that			All residents that have wound been referred to the facility sound care physician by the Administrative Licensed Pract for follow up and treatment evare managed care clients and nurse practitioner experience care. All current residents with have been referred to the concare physician on 02/11/2022 not already being seen by this The contract wound care phyweekly visits and will assess weekly. The Administrative Li Practical Nurse will accompand contract wound care physicial visits to ensure that any need changes are properly ordered into the resident schart. In the Administrative Licensed F	tical Nurse ven if they I have a Id in wound In wounds It tract wound If they were Is physician. Is sician makes wounds censed In y the In on his I and entered In event that	

Facility ID: 923196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER		1 2: *******	STREET ADDRESS, CITY, STATE, ZIP C	•	/17/2022
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ALEXANDRIA PLACE			1770 OAK HOLLOW ROAD		
			GASTONIA, NC 28054		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686 Continued From	page 37	F 6	886		
resembled a blist further stated she and completed tre with wound clean dressing to the area aware she was stassessment on R had shown her he Nurse #1 indicated provider book for the resident on he she had done the several times and getting better and indicated the resiturning and repostand coccyx area assist her in turnifurther indicated the meals several time bed to assist in or coccyx. Nurse # resident into reposition getting up in refused to get up A physician's ordinated to get up	er with fluid in it. Nurse #1 e followed the standing orders eatment of cleaning the areas ser and applying a foam reas. She said she was not supposed to complete a wound desident #106 and said no one ow to do that at the facility. It is she had placed a note in the the Nurse Practitioner to see for next round. Nurse #1 said of dressing on the resident of stated her wound was not of the had gotten worse. Nurse #1 dent was noncompliant with sitioning to offload her buttock and wouldn't allow the staff to ong and repositioning. She offloading her buttocks and offloading and tried to talk the offloading and tried to talk her offloading and repositioning.	F	Nurse is not available to co assessments, do dressing of accompany the contract work physician, one of the Nurse fulfill those duties. MEASURES AND/OR SYS CHANGES MADE OR TO BENSURE THE DEFICIENT DOES NOT RECUR: The facility has designated Administrative Licensed Prast the individual that will be skin assessments, wound changes, and notifications and Physician. This Administrat Practical Nurse has been in 02/11/2022 and assisted the Nursing and two Nurse Mal completing skin audits and for all residents on 02/11/20 facility consultant conducte of the Administrative License Nurse and also in-serviced Nursing and two Nurse Mal The results of the audit shoresidents receiving wound a currently receiving the correand that no new skin issues. The facility has also in-servithat are working on 02/11/2 shift (7am-7pm) on the proposition of Nurse Practical Nurse, Nurse Practical Practi	changes, or to bund care a Managers will a Managers in a Managers are will a Managers as well. A Managers as well a Managers and Manag	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345441	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	0-10-1-1		STREET ADDRESS, CITY, STATE, ZIP CODE	02	/17/2022	
NAME OF FI	NOVIDER OR SUFFLIER			, , ,			
ALEXAND	RIA PLACE			1770 OAK HOLLOW ROAD			
				GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page	e 38	F 68	6			
	12/10/21 revealed the for "follow up visit for breakdown." Integun and all its layers) was poor healing of woundescribed in the note: (stripped of covering) sheared off over bilat buttocks, and coccyx diagnosed by the NP ulcer of buttock limite. The plan was to "con wound cleanser and a dressing daily and as worsen or stall in heat contingency plan was indwelling urinary cat declines." A review of the physic #106 revealed there was	needed. Notify if areas ling process." The consider temporary		The unit nurses have been in-set the proper way to assess, docur notify the physician of any skin is may be brought to their attention CNAs. CNAs were in-serviced of do to prevent pressure ulcers, not the nurse of resident refusals of and repositioning, notifying nurs resident refusals to get out of be what skin changes they need to and to report these to the unit nut These in-services were conducted outside facility consultant and in Director of Nursing as a participal Director of Nursing will continue in-service all staff 02/11/2022 02/12/2022 to ensure that all star received in-servicing on the proper protocols. Any new agency staff be coming to the facility in the further than the start of their ensure that they are aware of the facility sprotocol and what to devent that a skin issue appears of	ment, and ssues that h by the n what to otifying turning es of ed, and watch for urse. ed by an cluded the ant. The to off have ber that may sture will ir shift to e o in the		
	(NP) on 02/01/22 at 3 the resident on 12/10 denuded areas of she and coccyx area. Du the NP, she referred wound not a non-presbuttocks as she had non 12/10/21. She starkesident #106's treat note dated 12/10/21 twound cleanser and a	th the Nurse Practitioner 3:12 PM revealed she saw /21 and she had multiple eared skin on her buttocks ring the conversation with to the wound as a pressure essure chronic ulcer of the noted in her progress notes ted she had written in ment plan on her progress to clean the areas with apply antibiotic cream and		their shift. The Nurse Practitioner has beer in-serviced by the facility Admini the proper protocol for writing or notifying the Nursing Staff of any in orders. She has also been infected that she is to follow all wounds of weekly basis or more often if new is to report off to the Director of and Administrator any changes if or wound orders. This report will in writing. The facility Administrator	strator on ders and y change ormed on a eded and Nursing in wounds be made utor has		
		essing daily and as needed. Id that she had not written		established a new protocol wher wound stage II or greater will	eby any		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR M	<i>J.</i> 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	' '	E SURVEY PLETED
		345441	B. WING				C / 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	71172022
					770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE				ASTONIA, NC 28054		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	Continued From page	- 39	F	686			
			'		automatically be referred to the Centre	net	
		ent in the physician orders ne nurses would have known			automatically be referred to the Contra Wound Care Physician. The Administr		
		w to perform the care for			contacted the Contract Wound Care	alui	
	Resident #106's pres	•			Physician, the Attending Physician, ar	nd	
	-	106 as arousable but said			Attending Nurse Practitioner on	ıu	
		ate a lot with her. She			02/11/2022 and has informed each of		
	described her appetite as waxing and waning and				them of the protocol for writing orders	and	
		le during the time she had			notifying the staff of any change in ord		
	her wounds and was			, , , ,			
	while in the bed and v			All residents that have wounds have n	ow		
	the bed and refusing			been referred to the facility□s contrac	İ		
	given her comorbiditie			wound physician by the Administrative	!		
	decompensated cond	lition she stated Resident			Licensed Practical Nurse for follow up	and	
		unavoidable, and she also			treatment even if they are managed ca	are	
		expected her wounds to			clients and have a nurse practitioner		
	_	Γhe NP indicated the wounds			experienced in wound care. All curren		
		ource of her pain, but the			residents with wounds have been refe	rred	
		agnosed with chronic pain.			to the contract wound physician on		
		ited although she would			02/11/2022 if they were not already be	eing	
	•	wounds to have gotten			seen by this physician. The contract	.: . : 4 .	
		all poor health, she would			wound care physician makes weekly v	ISITS	
		urses to have notified her of			and will assess wounds weekly. The Administrative Licensed Practical Nurs		
	_	wound and she would have nds and possibly ordered a			will accompany the contract wound ca		
		placed. According to the			physician on his visits to ensure that a		
	,	red Resident #106 to the			needed treatment changes are proper		
		ause she had previous			ordered and entered into the resident	•	
	' '	nds and worked in a wound			chart. In the event that the Administrat		
		e wound was a stage II she			Licensed Practical Nurse is not availal		
		eat it but stated had she			to conduct skin assessments, do dres		
	_	d gotten worse she would			changes, or to accompany the contrac	-	
	have referred Reside	_			wound care physician, one of the Nurs		
	physician.				Managers will fulfill those duties.		
	Review of Resident #	106's Treatment			Additionally, the Director of Nursing w	II	
		d (TAR) for December 2021			review all skin assessments weekly fo	r six	
	_	g order: Cleanse area to			(6) weeks, bi-weekly for six (6) weeks		
		eanser, pat dry, apply			and monthly for six (6) months to insu	re	
	Allevyn (foam dressin	ng that removes fluid faster			that skin assessments are completed.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY	
		345441	B. WING			C 02/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	17/2022	
				1	770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE			G	GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 686	Continued From page	e 40	F 6	686				
	than regular dressing and as needed until r the order was 12/09/2 through 12/18/21 reve provided as ordered of	s) and change every 3 days esolved. Effective date of 21. The TAR from 12/9/21 ealed that treatments were every 3 days on 12/09/21, ind 12/18/21. There were no			The Director of Nursing will document reviews of documentation on a Quality Assurance form and will present this for to the Quality Assurance Committee for review.	rm		
	pressure ulcer assess Resident #106's stag NP's evaluation on 12 the medical record re	evealed no evidence of any sments completed for e II pressure ulcer after the 2/10/21. Further review of vealed no evidence wound obtained after the pressure ed on 12/9/21.			HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLA WILL BE EVALUATED The Director of Nursing S Quality Assurance checks will also be reviewe	AN		
	Aide (NA) #2 revealed Resident #106 on 12/Director of Nursing (Director Nursing (Director) Nursing and the Wound having a few the wound looked woo had seen it and taken	2/22 at 11:49 AM with Nurse d she had taken care of 1/19/21 and had asked the 2/20N) to come into her room ts wound. NA #2 stated the some bleeding in some areas of black on the ed she could not remember oul odor but said it could in't remember. NA #2 stated rse than the last time she in care of the resident on			by the QAPI Committee to ensure that solution is achieved, effective, and sustained. The Director of Nursing S Quality Assurance checks will also be reviewe by the QAPI Committee to ensure that solution is achieved, effective, and sustained. Date of compliance is 03/11/2022.	the d		
	Director of Nursing (I at the facility on 12/19 had been asked by th name) taking care of come into the room a she was performing in stated she went into the	8/22 at 6:42 PM with the DON) revealed she had been 9/21. The DON stated she he NA (could not recall her the resident on 12/19/21 to nd look at her wounds while incontinence care. The DON the room and looked at the eks and coccyx and stated						

CENTERS FOR INEDICARE & INEDIC	JAID SERVICES				OIVID IVC	7. 0930-0391
	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	` ′		CONSTRUCTION		PLETED
	345441	B. WING _			1	C 17/2022
NAME OF PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			17	70 OAK HOLLOW ROAD		
ALEXANDRIA PLACE			G/	ASTONIA, NC 28054		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEI	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
the pressure ulcer had worse as though the wound was to she called the Unit Manage about the wound and care of DON indicated she did the wordered and had placed and book for the NP to see their rounds. The DON further in have completed an assessing had not done so and could she had not documented he wounds. She said she show wound assessment with me NP to review on her next room The DON explained the NP days per week and available needed. The facility was unable to leave placed in the provider to show wounds on book tom. Two (2) absorbed placed on buttocks. Wound in provider book." The note provider book for the NP to her next rounds in the facility A phone interview was atter 11:30 AM, 02/03/22 at 9:26 3:31 PM with Nurse #2 with The facility was unable to leave placed in the provider book 12/21/21.	unneling. She said r at home to ask her of the wound. The wound care as obte in the provider resident on her next indicated she should ment of the wound but not remember why er observation of the uld have completed a reasurements for the unds at the facility. was at the facility 3 re by phone as read 12/21/21 written at led "NA came to get ottom. No dressings read to communication put reases a c	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345441	B. WING_			02/1	; 17/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		UZ/ I	1112022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 686	A nursing progress not at 6:38 PM by Nurse; was "observed not in morning. Not able to able to stick her tongular her usual self. DON in normal baseline. Dire family and ask if they Family member requedepartment for further contacted. NP gave (emergency department transient ischemic att. 107/65, 105, 99.0, 97. A phone interview wa 11:31 AM, 02/03/22 a 3:33 PM with Nurse # Resident #106's hosp revealed she was adron 12/22/21 through to (ED) to the ICU (Interresident was evaluate and altered metal stated decubitus ulcer that we the facility where she diagnosed with acute encephalopathy, hyperespiratory failure, and resident had a large for that would likely requipossibly debridement further management a critical care unit. The broad-spectrum antib	oted dated 12/22/21 written #5 revealed Resident #106 her baseline orientation this respond to commands, not ue out. No grasp reflex. Not notified for comparison to exted from DON to call wanted resident sent out. ested send to emergency revaluation. On call order to send to ED ent) to rule out possible eack (TIA)/stroke. Vital signs % and blood sugar 127." Is attempted on 02/02/22 at to 9:28 AM and 02/03/22 at 5 with no return call. Italial admission notes mitted to the local hospital he emergency department asive Care Unit). The end for generalized weakness cus. The resident had a resided. The resident was kidney injury, hepatic ernatremia, lactic acidosis,	F 6	86			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF B		343441	B. WING _		ATTENT ADDRESS SITV STATE TIP SORE	02/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALEXAND	RIA PLACE				770 OAK HOLLOW ROAD		
				(GASTONIA, NC 28054		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG	NEGOLATORI ORI	REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)		
F 686	Continued From page	. 42		200			
F 000	Continued From page		F (686			
	A phone interview wa	•					
		ysician on 02/03/22 at 11:30					
	· ·	PM and 02/03/22 at 4:00					
	PM with no return cal	I.					
	An interview on 02/03	3/22 at 6:42 PM with the					
		should have been weekly					
		cumented for Resident #106					
		had developed a stage II					
		2/09/21. She stated she					
	contributed some of t	he breakdown to the agency					
		The DON further stated she					
		ement bedside rounding so					
	the nurses were looki	ing at the residents while					
	giving report. She inc	dicated they had already					
	revamped their 24-ho	our reporting sheets to					
	include labs and x-ray	y reports so the nurses					
		y pending labs or reports.					
		cated since they were using					
		had started bringing them					
		nly and had included them on					
		N said she couldn't explain					
		weekly skin assessments					
		nd stated there were always					
		a resident's skin during					
		lowers, baths and when					
	_	aid the nurses should have with the skin assessments if					
		get the resident to allow them he DON stated she realized					
		eed to provide additional					
		and the nurses about skin				ſ	
		und care. She further stated					
		ask the wound doctor if he				ſ	
		education to the NAs and the				ſ	
		unds. According to the DON,				ĺ	
		sessments to be completed				ĺ	
	•	for wound care to be written				ſ	
		wound care to be done by				ſ	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345441	B. WING_			C 02/17/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		02/11/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	Additionally, the DO some education wiregarding the proced DON stated their newritten orders were physician order she on progress notes. Were not immediate record so she would wanted carried out of the resident's mediate record so she would wanted carried out of the resident's mediate record so she would wanted carried out of the resident's mediate record so she would wanted carried out of the resident's mediate record so she would wanted carried out of the resident's mediate so will be a so wi	on stated they would be doing the the Nurse Practitioner less for writing orders. The formal process for verbal or the for them to be written on the lests not in the treatment plan. She indicated the NP notes lest available in the resident's defined to write any orders she in the physician order section ledical record. The Administrator on 02/03/22 at the had just taken over the ministrator in the middle of the stated she quickly found less that were not in place that less sments and wound care to define and stated it should have the growth of the residents. President and owner was the Jeopardy on 02/10/22 at lients who have suffered, or a serious adverse outcome as	F 68	36		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345441	B. WING			02/	17/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALEXAND	RIA PLACE				70 OAK HOLLOW ROAD		
	T			GA	ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	weekly skin assessmagency nurses and issues by the agency has also identified the failed to actually writted dressing from every facility staff of her de Nurse Practitioner in of 12/10/2021 the chwrite an order as is to notify anyone in Nurse follow the wound her note that a change in been done. The facil Nurse Practitioner's a full week to two we and was not aware corder to change the dressing. These issue wound order not beind deterioration of the wordsening did not concern the decause she though completed them. The provider book has not alexandria Place and are needed for Resident #106 is not alexandria Place and alexandria P	nents not being completed by n a failure to report skin y CNAs. Alexandria Place at the Nurse Practitioner e the order to change the three days to daily or to notify esire to change the order. The cluded in her progress noted tange in order but failed to the facility's system or to sing of the need to change a Practitioner also failed to the facility of the need to change a Practitioner also failed to the facility of the need to change a Practitioner also failed to the dictated progress notes until each after the note is dictated of the Nurse Practitioner's frequency of the wound the led to Resident #106's the granged and to the wound not being noted timely. In was not aware that the the day and was not aware that wound assessments, or not been done. The Director complete these tasks herself at the floor staff had a missing note from the of been found. I longer a resident at determine the process of the therefore, no interventions	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		345441	B. WING		C 02/17	//2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		12022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	Specify the action the process or system for adverse outcome frow when the action will	to be affected by this practice. The entity will take to alter the sailure to prevent a serious om occurring or recurring, and be complete:	F 68	6		
	The facility has designated an Administrative Licensed Practical Nurse as the individual that will be completing all skin assessments, wound dressing changes, and notifications to the Attending Physician. This Administrative Licensed Practical Nurse has been inserviced on 02/11/2022 and assisted the Director of Nursing and two Nurse Managers in completing skin audits and order audits for all residents on 02/11/2022. An outside facility consultant conducted the inservice of the Administrative Licensed Practical Nurse and also inserviced the Director of Nursing and two Nurse Managers as well. The results of the audit showed that all residents receiving wound treatments are currently receiving the correct treatment and that no new skin issues exist. The facility has also inserviced all staff that are working on 02/11/2022 on first shift (7am-7pm) on the proper protocol for notifying the Unit Nurse, Administrative Licensed Practical Nurse, Nurse Managers, or Director of Nursing of any skin breakdown or skin integrity issues. The unit nurses have been inserviced on the proper way to assess, document, and notify the physician of any skin issues that may be brought to their attention by the CNAs. CNAs were inserviced on what to do to prevent pressure ulcers, notifying the nurse of resident refusals of turning and repositioning, notifying nurses of resident refusals to get out of bed, and what skin changes they need to watch					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	ETED
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F 686	inservices were corconsultant and inclusas a participant. The continue to inservice 02/12/2022 to ensure inservicing on the pagency staff that mathe future will be inshift to ensure that protocol and what the issue appears during. The Nurse Practition the facility Administ writing orders and reany change in orderinformed that she is weekly basis or moreport off to the Direct Administrator any corders. This report facility Administrator Physician, the Atter Nurse Practitioner of informed each of the orders and notifying orders. All residents that have referred to the facility hadministrative Lefollow up and treatmer care clients. Any cube referred to the couplet of the practical Nurse will this service. The Administrative Lefollow up and treatmer care clients. Any cube referred to the couplet of the practical Nurse will practical Nurse will	ese to the unit nurse. These aducted by an outside facility uded the Director of Nursing e Director of Nursing will e all staff 02/11/2022 - re that all staff have received roper protocols. Any new ay be coming to the facility in serviced at the start of their they are aware of the facility's to do in the event that a skin	F 686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	ZIP CODE	<u> </u>	
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F 686	F 686 Continued From page 48		F	686			
	entered into the resi the Administrative L available to conduct dressing changes, of physician, one of the those duties. Date of alleged Imm 2/13/2022. Person	•					
	implementation is the Administrator. On 02/17/22 the facility's credible allegation was validated through record reviews, staff, and resident interviews. The facility provided education documentation for all staff on identifying and reporting a change in condition especially in skin integrity. In addition, the facility provided signed education sheets on the new system for completing skin assessments. The education provided detailed how all new admissions, readmissions would have an initial, weekly, and as needed skin assessments completed by the nurse. Interviews conducted with the nursing staff validated skin assessments were assigned to each resident and were flagged on the Medication Administration Record (MAR) for the nurse to complete. The nurses interviewed were able to explain with accuracy the new system implemented by the facility.						
	described the new s changes in the resid sheets and demons	were interviewed and system of describing any dents' skin on their shower trated a copy of the sheet and ht to mark any changes in the					

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F 686	Continued From pa	ge 49	F 6	86		
	and described the waskin assessments wall skin assessment electronic medical range Medication Administration and the medication Administration and the medication Administration and the scheduled shower of designee were respassessments daily assessments had but the DON explained	een thoroughly completed. I she or her designee verified npleted in detail and not just				
	The Administrator was interviewed and described in detail her education with the Nurse Practitioner (NP), Facility Medical Director and Wound Physician regarding referral of all wounds to the Wound Physician and collaboration between the NP, Medical Director and Wound Physician regarding resident wounds. A resident identified by the facility as alert and oriented with a wound was interviewed and reported his skin was assessed weekly by the nurse and nurse aide during his showers and he was followed by the Wound Physician for his					
	The credible allegal jeopardy removal w a removal date of 0 2. Resident #44 wa 9/17/21 with diagno	tion for the immediate as validated on 02/17/22 with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	NSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 686	humerus (arm bone and stage 2 pressure the admission Minim assessment dated 9, #44 had limited mob total assist with activ transfers. She was a pressure ulcer and fr pressure reduction in at risk for skin break. A review of Resident Assessment dated 1 the right shoulder, reunderneath breast albuttock and a purple side of the left heel. Resident #44's Would 12/16/21 indicated a left heel was identified described as unstage (dead tissue) with the length-1.8 cm (centimal depth-0 cm. The most recent quadated 12/17/21 indicated a left heel was identified assistance with all adminimation one so the shad one unstage slough/eschar prese pressure reducing derived the same and th	between shoulder and elbow) e ulcer of left buttock. ssment for Pressure Ulcer on um Data Set (MDS) /24/21 indicated Resident ility and required extensive to ities of daily living and admitted with an existing racture. She utilized a nattress. Resident #44 was down. ##44's Weekly Skin 2/15/21 indicated a rash to idness to left chest rea, a shear wound to the left discoloration to the distal and Assessment Report dated new pressure ulcer to the ed on 12/15/21. It was eable due to slough/eschar e following measurements: meters), width-1.8 cm and arterly MDS assessment ated Resident #44 was quired extensive physical ctivities of daily living and had ide of the upper extremities. eable pressure ulcer due to int and continued to have a	F	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		02/1//2022	
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F 686	needed, treatments assessment per factories pressure reduction. A review of a physic indicated to cleanse wound cleanser, pa and (collagenase oi (foam heel cup), wrichange daily. a. An observation Resident #44 was in Nurse #3. Nurse #3 heel with a gauze so She applied a mixtue collagenase ointme using a cotton swalt covered the wound applied a foam heel bandage roll. The pathe left heel had the measurements: len	fer to wound specialist as as ordered, weekly skin ility protocol and maintain mattress. Sian order dated 1/24/22 wound to left heel with t dry, apply (antimicrobial gel) intment), then gauze, then ap with (bandage roll) and of pressure ulcer care on made on 2/2/22 at 9:41 AM of 3 cleaned the wound to the left backed with wound cleanser. The of an antimicrobial gel and int to the surface of the wound of applicator. Nurse #3 with a petrolatum gauze, a cup and wrapped it with a pressure ulcer to the side of a following approximate in general side of the wound approximate in the side of the wound approximate in the side of the side of the side of the wound approximate in the side of the wound approximate in the side of the wound approximate in the side of the side of the side of the wound approximate in t	F 68	<u> </u>			
	depth-0.5 cm. The wound bed was clean with 80% granulation tissue observed surrounded by rough and peeling edges. A phone interview with Nurse #3 on 2/2/22 at 1:10 PM revealed she got confused with the order for Resident #44's left heel pressure ulcer. Nurse #3 explained that she followed a printout with step-by-step directions and items needed to perform the treatment. The printout included a petrolatum gauze but when she verified the order in the electronic medical record after she performed the procedure, she saw the order did not include the use of a petrolatum gauze. Nurse #3 further stated she called the Unit Manager to						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		OMPLETED
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F 686	gauze instead of a r specified in the order that she was going a doctor and clarify the heel pressure ulcer. An interview with the 2/2/22 at 3:00 PM resounded with the worded with the worded with the worded to the facility. I last time the wound #44's left heel pressure at the wound needed referred using collar the treatment order electronic medical real book of printouts to instructions to help performed wound care	eptable to use a petrolatum egular gauze which was er. The Unit Manager told her to check with the wound e order for Resident #44's left	F	886		
	gauze after she did Resident #44's treatment to her left heel pressure ulcer and told her she got confused because the printout still had a petrolatum gauze listed as one of the items needed but she failed to read the instructions that only included a regular gauze. The UM stated she told Nurse #3 she should have looked at the Treatment Administration Record in the electronic medical record and not relied on the printout. The UM also stated Nurse #3 should have used a regular gauze instead of a petrolatum gauze. An interview with the wound doctor on 2/3/22 at 10:44 AM revealed he had been following Resident #44 for over 2 months and had been treating her left heel pressure ulcer. It started as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	which he debrided staging to stage 4 weeks after it was he had ordered the because the wound moisture, but he dichanged the treatm collagenase ointmedebridement. The probably did not pictreatment and used regular gauze which harmful, but it adde wound and could consurrounding skin tis stated he expected and instructions where to Resident #4 An interview with the no 2/3/22 at 6:22 Finot have relied on looked at the order record before doing change. The DON issue with the UM awith the book or at current order and of the current treatments.	with unstageable necrosis and eventually advanced the due to exposure of fascia 2-3 first identified. At some point a use of petrolatum gauze d was too dry, and it needed scontinued it on 1/24/22 and nent to an antibiotic gel and ent because it needed wound doctor stated Nurse #3 ck up on the change in the dipetrolatum gauze instead of a ch might not have been ed a lot of moisture to the ause maceration of the sue. The wound doctor also I the nurses to follow his orders nen providing pressure ulcer 144. The Director of Nursing (DON) of M revealed Nurse #3 should the printout and should have on the electronic medical gresident #44's dressing stated she had addressed the and instructed her to do away least make a copy of the continually update it to reflect ent orders.	F	586				
	indicated the treatr left heel was left bl	nent order for Resident #44's ank on 1/15/22 and 1/31/22.						
		lurse #4 on 2/3/22 at 2:20 PM						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
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F 686	1/15/22 and did not r treatment to her left I had just come off orishe could not remem Resident #44's dress Nurse#4 confirmed the completed in her TAF treatment. An interview with Nurevealed she was sureatments on 1/31/2 on a hall when a nure #1 stated she took or around 9:00 AM and medication pass. Nueverything that went time to do the treatments on the time to do	emember doing the neel. Nurse #4 stated she entation around that time, but ober why she didn't do sing change to the left heel. hat if she didn't mark it off as R, she didn't do the rse #1 on 2/3/22 at 3:35 PM pposed to do all the 2 but she got pulled to work se had to go home. Nurse wer the medication cart got behind doing the urse #1 said that with on that day, she didn't have ents and she thought ssigned to do them. Unit Manager on 2/3/22 at e was not aware who had the treatments on 1/31/22 es on the halls were	F6	586	IENCY)		
	2/3/22 at 6:22 PM re that treatments and or getting completed as part of the problem who didn't even reali records that they need She further stated the breakdown in commencouraged the nurs and revamped their 2	vealed it was not acceptable dressing changes were not ordered. The DON stated was having agency nurses ze that there were treatment eded to review and complete. at there had been a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 686	Continued From page	e 55	F 6	86			
F 842	7:19 PM revealed she with wound care not I physician orders because been getting pulled to weren't able to do the being done and with acknowledged that cat to be. Resident Records - Id		F 8	42		3/11/22	
SS=B							
	must maintain medica that are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically org §483.70(i)(2) The fac all information contain	rdance with accepted Its and practices, the facility al records on each resident ented; e; and ganized ility must keep confidential ned in the resident's records, n or storage method of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	, ,	COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		02/11//2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	representative when (ii) Required by Lav (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domestic activities, judicial ar law enforcement pupurposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The forecord information a unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under State §483.70(i)(5) The m (i) Sufficient informa (ii) A record of the record	re permitted by applicable law; v;	F 84	12			

	OF DEFICIENCIES F CORRECTION	L IDENTIFICATION NUMBER.		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		، ا	c	
		345441	B. WING				17/2022	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	1772022	
				17	770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE				ASTONIA, NC 28054			
0(0)15	CHMMADV CT	CATEMENT OF DEFICIENCIES	10				(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	e 57	F	842				
. 0.12	This REQUIREMEN	!	J 4 Z					
	by:							
	-	on, record review and staff			" F-842:			
		/ failed to maintain an			CORRECTIVE ACTION(S) THAT WILL	_		
		Administration Record (TAR)			BE ACCOMPLISHED FOR THOSE			
		Resident #11 and #31)			RESIDENTS FOUND TO HAVE BEEN			
	reviewed for applicat				AFFECTED BY THE DEFICIENT			
	stockings.				PRACTICE:			
	The findings included	i :			The nurse that signed the Treatment			
		s admitted to the facility on			Administration Record for Resident #1			
	_	noses of coronary artery			and Resident #31 has been counseled			
	disease and chronic	congestive heart failure.			with concerning signing for medications			
	D . (D (/44/ BL :: 1			and/or treatments without first verifying			
		‡11's Physician orders			that the medications/treatments have			
	revealed the following	g: y antiembolism stockings in			been administered.			
		e off in the evening. Elevate			HOW OTHER RESIDENTS HAVE BEE	-NI		
	lower extremities as				IDENTIFIED FOR HAVING THE	-11		
	Tower oxironnings do	mach de possible.			POTENTIAL TO BE AFFECTED BY TH	ΙE		
	Observation of Resid	lent #11 on 1/31/2022 at			SAME DEFICIENT PRACTICE AND TI			
	10:12 AM while sittin	g in his wheelchair, revealed			CORRECTIVE ACTION(S) THAT HAV	Ξ		
	bilateral lower extrem	nity edema (swelling caused			BEEN OR WILL BE TAKEN:			
	by excess fluid trapp	ed in body tissues).						
					Any resident has the potential to be			
		lent #11 on 2/1/2022 at 12:05			affected by this practice. The nurse that	ıt		
		lying in bed and was not			signed the Treatment Administration			
	wearing antiembolisr	n stockings.			Record for Resident #11 and Resident			
	Observation of Regis	lant #11 an 2/2/2022 at 0:12			#31 has been counseled with and			
		lent #11 on 2/2/2022 at 9:43 dent sitting in his wheelchair.			in-serviced on 03/11/2022 concerning signing for medications and/or treatme	nte		
		antiembolism stockings and			without first verifying that the	110		
				medications/treatments have been				
					administered.			
		lent #11 on 2/2/2022 at 9:43						
		dent sitting in his wheelchair.			MEAGURES AND (25 2) (25 - 1) (2			
		antiembolism stockings and			MEASURES AND/OR SYSTEMIC			
	his feet and ankles w	vere edematous.			CHANGES MADE OR TO BE MADE T ENSURE THE DEFICIENT PRACTICE			
	I.		1		L ENOURE THE DEFIGIENT PRACTICE		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345441	B. WING	_		1	2	
NAME OF DE	ROVIDER OR SUPPLIER	343441	B. Wille	e.	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2022	
NAME OF P	ROVIDER OR SUPPLIER							
ALEXAND	RIA PLACE				770 OAK HOLLOW ROAD ASTONIA, NC 28054			
0.40.45	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	1		·		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	÷ 58	F	842				
	· -	11's TAR revealed staff had			DOES NOT RECUR:			
		bolism stockings had been						
	_	and removed each evening			All facility nurses have been in-serviced	d by		
	from 1/31/2022 through	gh 2/2/2022.			the Director of Nursing and Administrat	ive		
					Nurse on the importance of accurately			
	-	vith Nurse #6 on 2/3/2022 at			documenting on the Medication			
		was consistently assigned			Administration and Treatment	_		
		t11. Nurse #6 stated he was			Administration Records. The Director o	t		
		11 wore antiembolism			Nursing has emailed all agencies the			
		kings. Nurse #6 indicated he had signed the in error for application of the stockings. facility contracts with for temporary staffing and request that all nursing staff		ff				
	TAIX III CITOI TOI applic	cation of the stockings.			scheduled for Alexandria Place be	"		
	Interview with the Dire	ector of Nursing on 2/3/2022			in-serviced on the importance of			
		she expected Nurses to			accurately documenting on the Medica			
	verify completion of tr	eatments prior to signing			Administration and Treatment			
	the TAR.				Administration Records.The staffing			
					agencies have been instructed to			
	0 D : 1 1 1/04				in-service their staff and have their staf			
		admitted to the facility on			sign that they have been in-serviced or			
	disease and hyperter	ses of coronary artery			this topic prior to coming to the facility t work. The staffing agencies are emailir			
	disease and hyperter	131011.			the in-services and corresponding	ig		
	Review of Resident #	31's Physician's orders			signature pages back to the facility to			
	revealed the following	-			show that their staff have been			
	•	y antiembolism stockings to			in-serviced. The facility Administrative			
	bilateral lower extrem	ities every morning and			Nurse will conduct audits of resident			
	remove at bedtime.				charts daily for six (6) weeks, then wee	kly		
					for six (6) weeks, and then monthly			
		ent #31 on 1/31/2022 at			thereafter to ensure that facility and			
	2:24 PM revealed the				agency nurses are accurately			
	and no antiembolism	hite socks, slip-on shoes			documenting on the Medication Administration and Treatment			
	and no anticinibulish	atominga.			Administration Records. The			
	Observation of Resid	ent #31 on 2/2/2022 at 3:13			Administrative Nurse will record the			
		dent sitting in her wheelchair			results of these audits on a Quality			
		nite socks and shoes on.			Assurance form and will present the for	m		
		wearing antiembolism			to the Quality Assurance Committee fo			
	stockings.				review.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345441	B. WING				C 17/2022
	ROVIDER OR SUPPLIER			ST 17	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD ASTONIA, NC 28054	<u> 021</u>	1//2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Observation of Resid AM revealed her sitting pink and white socks stockings. Review of Resident # through 2/3/2022 revisions application completed every day Telephone interview was 2:59 PM revealed her to care for Resident # stockings. Nurse #6 application of the stockings. Nurse #6 application of the stockings. Nurse #6 application of the stockings. Inferview with the Dirat 6:26 PM revealed everify completion of the TAR. Infection Prevention of the TAR. Infection Prevention and CFR(s): 483.80(a)(1) §483.80 Infection Control of the the TAR. Infection prevention and designed to provide a comfortable environment and train diseases and infection program. The facility must estation of the the thickness and infection program. The facility must estation in the stocking with the program. The facility must estation in the stockings and infection program. The facility must estation in the stockings and infection program. The facility must estation in the stockings are stockings.	ent #31 on 2/3/2022 at 8:53 ng in her wheelchair wearing and no antiembolism #31's TAR for 1/31/2022 ealed the antiembolism had been signed off as with Nurse #6 on 2/3/2022 at was consistently assigned #31. Nurse #6 stated he was #31 wore antiembolism stated he had signed for ckings in error. ector of Nursing on 2/3/2022 she expected Nurses to reatments prior to signing #8 Control ((2)(4)(e)(f) Introl blish and maintain an and control program a safe, sanitary and ment and to help prevent the ensmission of communicable ens. Drevention and control blish an infection prevention (IPCP) that must include, at		342	HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLA WILL BE EVALUATED The Administrative Nurse will record the results of these audits on a Quality Assurance form and will present the for to the Quality Assurance Committee for review. The Administrative Nurse will a present the Quality Assurance form to the QAPI Committee for review to ensure the the solutions are achieved and sustained Date of Compliance is 03/11/2022.	e rm r Iso the hat	3/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345441	B. WING		C 02/17/2022			
NAME OF PROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	1772022	
ALEVANDRIA DI ACE			17	770 OAK HOLLOW ROAD			
ALEXANDRIA PLACE			G	ASTONIA, NC 28054			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
reporting, investigatinand communicable distaff, volunteers, visito providing services und arrangement based u conducted according accepted national states \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and trant to be followed to preven (iv) When and how iso resident; including but (A) The type and durate depending upon the ininvolved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected skeep contact with residents contact will transmit the (vi) The hand hygiene by staff involved in directions.	em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, allance designed to identify ole diseases or a can spread to other; in possible incidents of se or infections should be assission-based precautions sent spread of infections; olation should be used for a troot limited to: attorn of the isolation, infectious agent or organism at the isolation should be the ole for the resident under the ses under which the facility sees with a communicable kin lesions from direct on their food, if direct in edisease; and procedures to be followed	F	880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345441 NAME OF PROVIDER OR SUPPLIER ALEXANDRIA PLACE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	COMPLETED	
		345441	B. WING		C 02/17/2022	
		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		02/11/2022		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 880	\$483.80(e) Linens. Personnel must ha transport linens so infection. \$483.80(f) Annual IThe facility will consider the facility was a control and failed to wear eye for the findings included the facility was located facility was located facility was located transmission for COT the CDC guidance prevention and Cothealthcare Personal	review. duct an annual review of its neir program, as necessary. NT is not met as evidenced tions, record reviews, and staff ity failed to implement their licies and the Centers for d Prevention (CDC) etices for COVID-19 when 5 of Nurse Aide (NA) #6, NA #1, NA #5) working on the 100-hall protective gear while providing These failures occurred during mic. ed: htters for Disease Control and COVID-19 Data Tracker on that the county where the had a high level of community DVID-19. e entitled, "Interim Infection introl Recommendations for nel During the Coronavirus	F 88	" F-880: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEE AFFECTED BY THE DEFICIENT PRACTICE: The facility QAPI Committee conduct Root Cause Analysis of the deficient practice to determine what corrective action needed to be taken. The Director of Nursing will conduct in services with all facility nursing staff of wearing of proper eyewear and how t correctly wear eyewear. These in-ser will begin on 3-7-2022 and will continue through 3-11-2022. The Director of Nursing will also email agencies the facility contracts with for temporary staffing and request that all	ed a n- n o vices ue	
	Disease 2019 (CO' on 9/10/21 indicate under the section "	VID-19) Pandemic," updated d the following information Implement Universal Use of Equipment for HCP		nursing staff scheduled for Alexandria Place be in-serviced on wearing of proper eyewear and how t correctly wear eyewear. The Director	0	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION		TE SURVEY MPLETED		
	345441 B. WING					C 2/17/2022	
NAME OF PROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP COD	•	2/11/2022	
	101.52.1 01.1 00.1 2.2.1			1770 OAK HOLLOW ROAD	-		
ALEXAND	RIA PLACE			GASTONIA, NC 28054			
				·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880 Continued From page		e 62	F 88	30			
	patient presenting for	ction is not suspected in a care (based on symptom), HCP working in facilities		Nursing will send each staffin copy of the in-service materia ask that the agencies return sattendance sheets via email.	als and will		
	transmission should a Protective Equipment including eye protect	also use PPE (Personal t) as described below tion (i.e., goggles or a face front and sides of the face)		HOW OTHER RESIDENTS IN IDENTIFIED FOR HAVING TO POTENTIAL TO BE AFFECT SAME DEFICIENT PRACTIC CORRECTIVE ACTION(S) TO BEEN OR WILL BE TAKEN:	HE ED BY THE E AND THE		
	A review of the facility policy entitled, "COVID-19 Personal Protective Equipment - Eyewear," revised December 2021 indicated: 2. When the county transmission rate is substantial to high protective eyewear must be worn in all areas and all situations where the employee could have an encounter with a resident (i.e. providing direct resident care, walking down the hallway, in dining rooms, etc.), regardless of whether the facility has any actual positive cases. 3. Approved Personal Protective eyewear for this facility includes: facility approved goggles and			The facility QAPI Committee Root Cause Analysis of the d practice to determine what co action needed to be taken an that all residents have the po- affected by this practice.	eficient prrective d determined		
				The Director of Nursing will conservices with all facility nursing wearing of proper eyewear and correctly wear eyewear. These will begin on 3-7-2022 and withrough 3-11-2022.	ng staff on and how to se in-services		
	face shields. An indiv sunglasses are not con eyewear and are not of facility provided pro	vidual's personal glasses or onsidered protective permitted to be used is lieu otective eyewear.		The Director of Nursing will a agencies the facility contracts temporary staffing and requenursing staff scheduled for Al Place be in-serviced on	s with for st that all exandria		
	on 02/02/22 from 9:3: were six (6) NAs in the were not wearing eye NA #4 was wearing head and was seen g	bbservation of the 100-hall 5 AM to 10:01 AM there he hall. Five (5) of the 7 NAs e protection on their eyes. her goggles on top of her going in and out of resident residents and other NAs with		wearing of proper eyewear and correctly wear eyewear. The Nursing will send each staffin copy of the in-service material ask that the agencies return stattendance sheets via email.	Director of g agency a als and will		

Facility ID: 923196

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
						С	
		345441	B. WING _			02	2/17/2022
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
				17	70 OAK HOLLOW ROAD		
ALEXANL	ORIA PLACE			G	ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	ge 63	F 8	380			
	· ·	1 was observed providing care					
		idents and was noted to be			MEASURES AND/OR SYSTEMIC		
		with his blanket and spread			CHANGES MADE OR TO BE MADE T	.0	
	_	goggles up on her head and			ENSURE THE DEFICIENT PRACTICE		
		A #5 was stopping to assist			DOES NOT RECUR:		
	_	way and assisted a resident					
	down the hallway in	to the shower and provided			The Director of Nursing, The Infection		
	her assistance with	her shower while wearing her			Control Preventionist and the		
		er head. NA #5 was observed			Administrator will begin observations o	f	
		ning out of the shower room			staff on each shift (7a-7p and		
		th her goggles still positioned			7p-7a)beginning 03-07-2022 for wearing	ıg	
	-	NA #6 was going in and out			of protective eyewear and properly		
		esidents and was in the h her regular glasses on and			wearing the protective eyewear until compliance is achieved. The results of	f	
		shield. NA #2 was interacting			these audits will be recorded on a Qua		
		other staff in the hallway and			Assurance Form and will be presented	-	
		rooms assisting with resident			the Quality Assurance Committee for	10	
		s or face shield. NA #2 was			review.		
		or any eye protection while					
	providing resident c	are and charting out in the			HOW THE CORRECTIVE ACTION(S)		
	hallway.				WILL BE MONITORED TO ENSURE		
					THAT its SOLUTIONS ARE ACHIEVED)	
		02/2022 at 10:02 AM with NA			AND SUSTAINED AND HOW THE PLA	٩N	
		ner second day at the facility			WILL BE EVALUATED		
		e residents. NA #6 stated she			T 5: ((N : T) (()		
		y anyone at the facility she			The Director of Nursing, The Infection		
	caring for the reside	ggles or a face shield while			Control Preventionist and the Administrator will present the results of	f	
	caring for the reside	ents.			their audits to the Quality Assurance	ı	
	An interview on 02/	02/22 at 11:25 AM with NA #1			Committee for review. The results of the	ie.	
		d for an agency and had			audits will also be presented to the QA		
		y for a while. NA #1 stated			Committee for review to ensure that the		
		rientation and it included			solutions are achieved and sustained.		
		nal protective equipment					
		istancing. She stated she					
		her goggles up on her head			Compliance date is 03/11/2022.		
		em back on but stated she					
		osed to have them on at all					
	times while providin	g care and in the resident					

		` '		(X3) DATE SURVEY COMPLETED		
	345441	B. WING		C 02/47/2022		
NAME OF PROVIDER OR SUPPLIER ALEXANDRIA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054			
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION		
hallways when resithey were today. An interview on 02/revealed she worked worked at the facility orientation to the factor on the residents she regular basis. NA was supposed to wat all times while in had pushed her go because they were forgot to pull them. An interview on 02/revealed she worked the facility for sewhen she came to orientation which in use and wear of Prusually had her gog she didn't have the she got a face shie she had provided reseveral hours before An interview on 02/revealed she had wyears. She stated in-services on infective of PPE. She seresident a shower of sweating and had get the seresident and had get to the seresident and the seriesident and the seresident and the seriesident and the seresiden	dents were in the hallway as 102/22 at 11:45 AM with NA #4 2d for an agency and had 2d yon an as needed basis for A #4 stated when she first A they provided her an acility and gave her information a would be taking care of on a a #4 further stated she knew she are goggles and a face mask athe resident care areas but aggles up on top of her head afogged up and said she just aback down over her eyes. 102/22 at 12:08 PM with NA #2 and for an agency but had been averal months. NA #4 stated athe facility, she had received accluded PPE and the proper PE. NA #4 further stated she aggles on and had not realized and put it on. She stated assident care that morning for are putting on a face shield. 102/22 at 12:36 PM with NA #5 avorked at the facility for several athey received frequent attending the proper attend she had been giving a bon the 100 hall and was a bushed her goggles up on top	F 88				
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and sweaty and had pushed them up on her head. NA #5 stated she had not realized she had been in the hallway and in the shower with the resident with her goggles on her head the whole time and said she had not worn the goggles while providing the resident her shower. An interview on 02/02/22 at 3:04 PM with the Unit Manager revealed she had not noticed the NAs on the hallway without their goggles on. She stated she was concentrating on what she was doing and had not noticed there were 3 NAs with goggles on top of their head instead of on their face, 1 NA with just glasses on and one NA with no glasses, goggles, or a face shield on. She further stated all the NAs working on the 100 and 200 hallways had been educated they were to wear goggles on their eyes and a mask on their face at all times while in the hallways and while in resident rooms providing care. An interview on 02/03/22 at 9:54 AM with the Infection Preventionist (IP) and the Nurse Consultant (NC) revealed with the current high level of community transmission, all staff had been educated to wear a mask and goggles at all times and especially now with positive cases in the building. The IP stated COVID education was ongoing all the time and they were performing audits to ensure staff were wearing PPE, performing hand hygiene between residents and donning and doffing PPE appropriately. They both indicated the Administrator gave weekly updates to all staff and just yesterday all staff had been educated again regarding wearing PPE	F 880	down off her head and She stated she knew the goggles over her and sweaty and had head. NA #5 stated been in the hallway a resident with her gog time and said she had providing the resider. An interview on 02/0 Manager revealed shound the hallway withous tated she was conditing and had not not goggles on top of the face, 1 NA with just an oglasses, goggles, further stated all the 200 hallways had be wear goggles on the face at all times whill resident rooms provided in the hallway shad be wear goggles on the face at all times whill resident rooms provided in the hallway shad be wear goggles on the face at all times whill resident rooms provided in the hallway shad be wear goggles on the face at all times whill resident rooms provided in the hall the hall the building. The IP ongoing all the time audits to ensure staff performing hand hydronning and doffing both indicated the Adupdates to all staff at the hall the hall the staff at the hall the staff at the hall the hal	and put them on her eyes. If she was supposed to wear of eyes but had just gotten hot pushed them up on her she had not realized she had and in the shower with the ggles on her head the whole ad not worn the goggles while and the shower. If the shower. If the had not noticed the NAs at their goggles on. She tentrating on what she was officed there were 3 NAs with heir head instead of on their glasses on and one NA with a or a face shield on. She NAs working on the 100 and then educated they were to if eyes and a mask on their e in the hallways and while in ding care. If the standard of the stand	F	380			

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F 880	while in the building. expected all staff to wor face shield at all tin An interview on 02/03 Director of Nursing (Expectation while the transmission in the consecution that all stage in the expectation that all stage in resident care resident care. An interview with the 7:32 PM revealed shoulding as the Admir December 2021. Shout there were systemeded to be in place stated they had begun systems when their Cand then all their atteent outbreak and protection that the protection of the place in the	The IP further indicated she year their mask and goggles mes. 8/22 at 6:30 PM with the DON) revealed it was her	F 8	80			