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F 000	INITIAL COMMENTS An onsite revisit was conducted on 05/14/204 through 05/16/2024. Tags F677, F687, F761, and F804 were corrected as of 05/16/2024. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Event ID# ZDXN12.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		

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

Electronically Signed

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.

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F 842	Continued From page 1 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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Based on record review and staff interviews, the facility failed to maintain an accurate Treatment Assessment Record (TAR) for skin assessments for 1 of 2 residents (Resident #2) sampled for accuracy of resident records (skin assessments).

The findings included:

Resident #2 was admitted to the facility on 6/10/19 with diagnoses inclusive of quadriplegia.

A quarterly minimum data set (MDS) dated 1/11/24 indicated Resident #2 was cognitively intact and required set up with eating, supervision with oral hygiene, dressing and bed mobility; Resident # 2 was dependent for transfers.

A review of a physician's order dated 1/1/24 indicated weekly skin assessments were to be completed every Wednesday on day shift.

A review of February 2024 TAR indicated the 2/7/24 skin assessment was completed but the nurse who initialed/signed the TAR for 2/7/24 could not be identified. Nurse # 3 signed that skin assessments were completed for Resident #2 on 2/14/24 and 2/21/24 (day shifts). The nurse who initialed/ signed the TAR on the 2/7/24 skin assessment, could not be identified.

Further review of the medical record indicated there were no weekly skin assessment documentation diagram sheets completed for Resident #2 on 2/7/24, 2/14/24, and 2/21/24. Due to the lack of documentation diagram sheets, there was no record of what potential skin concerns may have been discovered during the skin assessments.

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F 842	Continued From page 3 A review of March 2024 TAR indicated skin assessment was blank on 3/6/24 which indicated the skin assessment was not completed. Further review of the medical record indicated there were no weekly skin assessment documentation diagram sheets completed for Resident #2 on 3/6/24. Due to the lack of documentation diagram sheets, there was no record of what potential skin concerns may have been discovered during the skin assessments or if the skin assessment was completed at all. During a phone interview on 5/15/24 at 3:35 pm Nurse #3 revealed she worked with Resident #2 on 2/14/24 and 2/21/24 if the TAR indicated her initials were on those days. Nurse #2 further indicated she usually completed skin assessment documentation diagram forms while she performed the skin the assessment. However, Nurse #2 stated she could not recall why she did not complete the documentation diagram forms (2/14/24 & 2/21/24) that were required when she "initialed/signed" the TAR. During an interview on 5/15/24 at 7:37 pm the interim Director of Nursing, (DON) # 1, indicated she began working at the facility on 5/1/24 and her expectation was for skin assessment documentation to be completed and documented as completed in the medical record. An attempt to contact the previous DON, DON #2, was unsuccessful.	F 842		
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	{F 867}		

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monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and

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systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

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§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigation survey completed on 12/08/21, the recertification and

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complaint investigation surveys completed on 10/03/22 and 02/01/24, and the revisit and complaint investigation survey that occurred on 03/28/24. This failure was for a deficiency in the area of Infection Control (F880) that was originally cited during the complaint investigation survey completed on 12/08/21 and subsequently recited during the recertification and complaint investigation survey completed on 02/01/24 and the revisit and complaint investigation survey completed on 3/28/24. Deficiencies in the areas of Treatment/Services to Prevent/Heal Pressure Ulcers (F686), Free of Accident Hazards/Surpervisions (F689) and Resident Records - Identifiable Information (F842) were originally cited during the recertification and complaint investigation survey completed on 10/03/22 and F689 and F842 were subsequently recited during the recertification and complaint investigation survey completed on 02/01/24. The tag F842 was also subsequently recited during the revisit and complaint investigation survey completed on 3/28/24. Deficiencies in the areas of Treatment/Services to Prevent/Heal Pressure Ulcers (F686), Free of Accident Hazards/Surpervisions (F689) and Resident Records - Identifiable Information (F842) and Infection Control (F880) were subsequently recited on the current revisit and complaint investigation survey of 05/16/2024. The repeat deficiencies during five surveys of record show a pattern of the facility's inability to sustain an effective QA program.

The findings included:

This tag is cross referred to:

F686: Based on record reviews and staff

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interviews the facility failed to complete and document weekly skin assessments as ordered by the physician for a resident with a known stage IV pressure ulcer to the sacrum and a known stage III pressure ulcer to the right heel for 1 of 3 residents (Resident #3) reviewed for the treatment and prevention of pressure ulcers.

During the recertification and complaint investigation survey completed on 10/03/2022, the facility failed to follow treatment orders for a stage 4 pressure ulcer.

F689: Based on record review, and staff interviews, the facility failed to prevent a resident (Resident #3) from being fed when his diet order was nothing by mouth (NPO) with continuous enteral tube feeding for 1 of 2 residents reviewed for gastrostomy tube care.

During the recertification and complaint investigation survey completed 02/01/2024, the facility failed to provide care in a safe manner when a resident's lower half of his body went off the other side of the bed during incontinence care with no injuries sustained.

During the recertification and complaint investigation survey completed 10/03/2022, the facility failed to provide care in a safe manner resulting in a resident falling from bed to the floor and sustaining a fracture to the left forearm.

F842: Based on record review and staff interviews, the facility failed to maintain an accurate Treatment Assessment Record (TAR) for skin assessments for 1 of 2 residents (Resident #2) sampled for accuracy of resident records (skin assessments).

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During the revisit/follow-up survey completed 03/28/2024, the facility failed to maintain complete and accurate medical records related to wound treatments.

During the recertification and complaint investigation survey completed on 02/01/24, the facility failed to maintain complete and accurate medical records related to a resident's blood sugar.

During the recertification and complaint investigation survey completed on 10/03/22, the facility failed to document in the medical record a resident's death.

F880: Based on observations, record review, and staff interviews, the facility failed to implement their Infection Control Policy for hand hygiene/handwashing when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure when providing wound care to 1 of 3 residents (Resident #3) and when Unit Manager #1 did not perform hand hygiene according to the facility's policy and procedure when providing gastrostomy tube site care for 1 of 2 residents (Resident #3) reviewed for infection control practices.

During the revisit follow-up survey completed 03/28/2024, the facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy, when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure when providing wound care.

During the recertification and complaint

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{F 867}	Continued From page 10 investigation survey completed on 02/01/24, the facility failed to implement their infection control policies for the safe handling of soiled laundry (laundry staff) and failed to follow standard precautions during the infection control observation. During the complaint investigation survey completed on 12/08/21, the facility failed to follow CDC guidelines when staff failed to wear eye protection while performing direct care during a COVID-19 pandemic. During an interview with the Administrator on 05/16/24 at 1:14 PM, she revealed the facility had been discussing everything associated with the revisit/follow-up plans of correction following their survey on 03/28/2024. These issues were discussed during their weekly QAA meetings. She stated that all department heads were present for the meetings, and they reviewed the educational plans and the current performance improvement plans. The Administrator revealed that the plans were set up prior to her start date but she would be afforded the opportunity to re-design and re-structure the performance plans in order to achieve compliance with all deficiencies. She also stated that she believed the plans had not been effective due to leadership changes, staff turnover, and the high use of agency personnel which created missed opportunities for extra oversight. She also revealed they were working closely with corporate consultants on the performance improvement plans.	{F 867}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	{F 880}		

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{F 880}	Continued From page 11 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	{F 880}		

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to implement their Infection Control Policy for hand hygiene/handwashing when the Treatment Nurse did not perform hand hygiene according to the facility's policy and procedure when providing wound care to 1 of 3 residents (Resident #3) and when Unit Manager #1 did not perform hand hygiene according to the facility's policy and procedure when providing gastrostomy tube site care for 1 of 2 residents (Resident #3) reviewed for infection control practices.

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The findings included:

The facility's policy entitled Handwashing/Hand Hygiene which is part of their Infection Control Policies and Procedures last revised 08/2019 under Policy Interpretation read in part:

7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:

b. Before and after direct contact with residents;

g. Before handling clean or soiled dressings, gauze pads, etc.;

m. After removing gloves;

8. Hand hygiene is the final step after removing and disposing of personal protective equipment (PPE).

9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

a. An observation of wound care by the Treatment Nurse with the oncoming Director of Nursing (DON) present in the room was made on 05/14/24 at 10:45 AM. The Treatment Nurse had her supplies laid out on a clean surface on the overbed table in Resident #3's room. The Treatment Nurse sanitized her hands, donned clean gloves, and proceeded to remove the old dressing with a small amount of serosanguinous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	R-C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT GASTONIA	969 COX ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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drainage on it from Resident #3's right heel and disposed of it in the trash can. She then doffed her gloves and without sanitizing her hands, donned new gloves, and proceeded to clean the heel wound with wound cleanser. After cleaning the wound bed, she doffed her gloves, sanitized her hands, and donned clean gloves and applied silver alginate to the wound bed and covered it with a bordered gauzed dressing. The Treatment Nurse then doffed her gloves, sanitized her hands, donned clean gloves, and proceeded to the sacral wound. After completing care of the sacral wound, she doffed her gloves, sanitized her hands, donned new gloves, and collected her supplies and the trash and left the room.

An interview on 05/14/24 at 5:40 PM with the Treatment Nurse revealed she realized she should have sanitized her hands after she removed the old dressing and before donning clean gloves before proceeding to clean the heel wound. She stated it was her error and she knew better and knew that she was supposed to sanitize her hands every time she removed her gloves but said she forgot to do it.

A telephone interview on 05/15/24 at 10:23 AM with the Infection Preventionist (IP) revealed any time gloves were removed the Treatment Nurse was supposed to sanitize her hands. The IP stated she had observed the Treatment Nurse performing wound care during her audits and she had done it correctly and was not sure why she had not performed it correctly but said she knew the Treatment Nurse knew the proper procedure for hand hygiene during wound care.

An interview on 05/16/24 at 1:07 PM with the interim Director of Nursing (DON) and the

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oncoming DON revealed it was the interim DON's expectation that the Treatment Nurse follow the proper procedure according to the policy and procedure for hand hygiene while providing wound care. The DON stated she had audited the Treatment Nurse and when audited she had followed the proper procedure for hand hygiene and did not understand why she had not followed the policy and procedure while being observed.

b. An observation of gastrostomy tube care by Unit Manager #1 with the oncoming Director of Nursing (DON) present in the room was made on 05/14/24 at 12:38 PM. Unit Manager #1 had her supplies laid out on a clean surface on the overbed table in Resident #3's room. She began by removing the towel with old tube feeding on it from around the gastrostomy tube and moved his shirt to expose the site to be cleaned. She proceeded to doff her gloves, and without sanitizing her hands donned new gloves and began cleansing the area around the tube insertion site with normal saline and gauze. After cleansing the site, she put a clean towel around the gastrostomy tube site, adjusted the resident's clothing and covered him with his bed covers. Unit Manager #1 doffed her gloves, sanitized her hands, and donned clean gloves and gathered the trash and left the room.

An interview on 05/14/24 at 3:31 PM with Unit Manager #1 revealed she knew she should have sanitized her hands after doffing her gloves and before donning clean gloves to provide gastrostomy tube site care to Resident #3. She stated she knew better but just forgot to do it.

A telephone interview on 05/15/24 at 10:23 AM with the Infection Preventionist (IP) revealed any

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time gloves were removed Unit Manager #1 was supposed to sanitize her hands. The IP stated she knew Unit Manager #1 knew the proper procedure for hand hygiene during gastrostomy site care and was not sure why she had not done the procedure correctly according to the hand hygiene policy and procedure.

An interview on 05/16/24 at 1:07 PM with the interim Director of Nursing (DON) and the oncoming DON revealed it was the interim DON's expectation that Unit Manager #1 follow the proper procedure according to the policy and procedure for hand hygiene while providing gastrostomy tube site care. The DON stated she knew Unit Manager #1 knew the proper procedure for hand hygiene and did not understand why she had not followed the policy and procedure while being observed.