STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345326	A. BUILDING ______ B. WING ______	05/30/2024

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WILLOWBROOKE COURT SC CTR AT MATTHEWS GLEN	**740 PAVILION VIEW DRIVE MATTHEWS, NC 28105**

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E 000	Initial Comments An unannounced recertification survey was conducted on 5/28/24 through 5/30/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NNVO11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 5/28/24 through 5/30/24. Event ID# NNVO11.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Nurse Practitioner (NP), and Pharmacist interviews the facility failed to maintain a medication error rate of less than 5% by having 3 errors out of 25 opportunities which resulted in an 12% medication error rate. This affected 1 of 3 residents observed for medication administration (Resident #57). Findings included: 1a. A Physician's order dated 5/21/24 read Ceftriaxone sodium (antibiotic) intravenous solution reconstituted 2 grams (gm), use 2 gm intravenously (IV) in the morning for sepsis until 6/27/24. A Physician's order dated 5/21/24 read Heparin	F 759	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with State law. F759 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	6/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 06/21/2024

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 759	Continued From page 1 (blood thinner) lock flush solution 10 units/ milliliter (ml), use 5 ml intravenously in the morning for after medication administration until 6/28/24, use SASH: saline flush, administer medication, saline flush, heparin flush. An observation and interview were made on 5/30/24 at 8:50 AM of Nurse #1 preparing Resident #57's medication. She removed a 10 milliliter (ml) normal saline (NS) flush and a heparin 5 units/ ml 5 ml flush from her medication cart. She then proceeded to take a bag of IV ceftriaxone (an IV antibiotic), IV tubing, the NS flush, and the heparin flush into Resident #57's room. Nurse #1 was observed to hang the bag of IV ceftriaxone sodium 2gm on the IV pole. She primed the IV tubing at Resident #57's bedside. Nurse #1 then cleaned the connection cap of the PICC line lumen with an alcohol swab. Nurse #1 opened the heparin flush from its packaging and connected the heparin flush to Resident #57's PICC line connection cap. Nurse #1 was stopped before she flushed Resident #57's PICC line with the heparin flush. Nurse #1 went back to her medication cart to review the flush orders for Resident #57's PICC line. After reviewing the PICC line flush orders on Resident #57's medication administration record (MAR), Nurse #1 said she was supposed to flush Resident #57's PICC line using the SASH (saline-administer medication-saline-heparin) method. She said she should have flushed the PICC line using a normal saline flush. Nurse #1 said she was nervous and got confused. 1b. Another observation was made on 5/30/24 at 9:45 AM of Nurse #1 disconnecting Resident #57's IV and flushing his PICC line. Nurse #1 was observed to take a NS 10 ml flush and a Heparin	F 759	IV/SASH On 5/30/24, the DON re-educated Nurse #1 regarding the proper procedure for the Saline Administration Saline Heparin (SASH) method. Nurse #1 Completed training with the ADON on 6/12/24 on facility protocol for IV medication administration. Nurse #1 completed a return demonstration of the SASH method on 6/17/24. An audit was conducted, and there were no other residents with IV medication orders Voltaren gel Nurse #1 re-educated by DON on 05/30/2024 regarding the proper measuring of Voltaren gel and application to the ordered site. Nurse #1 verbalized understanding of the education. Nurse #1 completed the Med Pass Fundamentals Video training on Medication preparation and safety security, The Basics, Route Specific Administration, and common errors on oral, ophthalmic, optic, nasal, enteral, topical, inhaled, subcutaneous, and suppositories on 06/08/2024.	

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F 759 Continued From page 2

5 unit/ml 5 ml flush from her medication cart and into Resident #57's room. She was observed to disconnect the IV tubing from Resident #57's PICC line. She cleaned the PICC line connection cap with an alcohol swab. She then held up an opened heparin flush to indicate which flush she intended to use first to flush Resident #57's PICC line, she did not connect the flush to the PICC line connection cap. Nurse #1 was stopped. She then proceeded to flush the PICC line with the 10 ml normal saline flush, followed by the 5 ml heparin flush. Nurse #1 said she was nervous and forgot which flush she was supposed to use first.

An interview was conducted with the Director of nursing on 5/30/24 at 9:55 AM. She said Nurse #1 should have flushed Resident #57's PICC line using the SASH method. She said Nurse #1 had received training on IV administration, which included flushing of IV devices. She said she was not sure why Nurse #1 failed to flush Resident #57 PICC line correctly, except that she was nervous.

An interview was conducted with the NP on 5/30/24 at 11:00 AM. She said there would probably be no adverse effect from using heparin to flush the PICC line before administering medication through the PICC line. She said Nurse #1 should have followed protocol and flushed the PICC line as ordered using the SASH method.

An interview was conducted with the pharmacist on 5/30/24 at 11:19 AM. The Pharmacist said there was no adverse reaction between heparin and ceftriaxone. She said there would not be an adverse effect to the resident. The Pharmacist said that the heparin flush dose was not enough

F 759

An audit was completed to identify residents with physician orders for Voltaren gel to ensure measuring cards were in place on 5/30/24.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Newly hired licensed staff will complete education with return demonstrations on the proper protocol for IV medication administration by DON/Designee.

DON re-ordered a measuring card for the Voltaren gel for resident #57 on May 30, 2024.

Licensed staff re-educated on proper measuring of Voltaren gel using the measuring guide and application to the ordered site by DON/Designee by 6/27/24.

Re-education of licensed staff with return demonstration on the proper protocol for the IV SASH method completed by DON/Designee by 6/27/24.

Indicate how the facility plans to monitor its performance to make sure that solutions are substantiated.

The DON/ Designee will audit weekly for two months, then every other week for two months, and then once a month for two months.

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F 759	Continued From page 3 to be absorbed systemically and adversely affect the resident, even if the resident received other anticoagulant medications. An interview was conducted with the Administrator on 5/30/24 at 11:56 AM. The Administrator said she expected Nurse #1 to follow the protocol for flushing of PICC lines and that Nurse #1 should have followed the physician's orders. 2. A Physician's order dated 5/22/24 read Voltaren External Gel (topical analgesic) 1% (Diclofenac Sodium (Topical)) Apply to right shoulder topically three times a day for osteoarthritis, apply 2 grams (gm) to right shoulder three times daily. An observation was made on 5/30/24 at 8:58 AM of Nurse #1 preparing and administering Resident #57's medications. She was observed to squeeze a quarter sized amount of Voltaren 1% gel onto her gloved hand four separate times and applied the gel to Resident #57's left lower back, right lower back, left side, and right shoulder. An interview was conducted with Nurse #1 on 5/30/24 at 9:32 AM. She stated had never measured Voltaren gel for administration. Nurse #1 said she was not aware that Voltaren gel was supposed to be measured or that there was a dose card to measure the grams to be administered. She said she should have only applied the Voltaren gel to Resident #57 right shoulder as it was ordered. She said she applied the Voltaren gel to other areas because Resident #57 had requested it. An interview was conducted with the Director of	F 759	The DON/Designee will submit the results of the audits monthly to the Quality Assurance Performance and Improvement (QAPI) Committee Meeting for six months. Indicate dates when corrective action will be completed The completion of the Plan of Correction is 6/27/24.	

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F 759	Continued From page 4	F 759		

Nursing (DON) on 5/30/24 at 9:55 AM. The DON said she had spoken to the pharmacy, and they confirmed Voltaren gel should be measured using a dosing card before being applied. She said she did not know why there was not a dose measuring card for Resident #57's Voltaren gel. She said the dose measuring card could have fallen out of the package or accidentally been thrown away. The DON stated that not measuring the Voltaren gel was a medication error. She said Nurse #1 should have only applied the Voltaren gel to Resident #57's right shoulder as specified in the order. She could not say why Nurse #1 applied the Voltaren gel to other areas.

An interview was conducted with the NP on 5/30/24 at 11:00 AM. She said Nurse #1 should have measured the Voltaren gel before administering the medication. She said Nurse #1 should follow the physician's orders and should have only administered the Voltaren gel to Resident #57's right shoulder as specified in the order.

An interview was conducted on 5/30/24 at 11:19 AM with the Pharmacist. She stated Voltaren gel should be measured using a dosage card before being applied. The Pharmacist stated that there was a maximum daily dose for Voltaren gel of 32 gm for the entire body. She stated if the maximum daily dosage was exceeded there could be adverse reactions. The Pharmacist explained Voltaren gel was a non-steroid anti-inflammatory (NSAID) medication. The Pharmacist said anytime an NSAID was used with an anticoagulant medication, there was always a labeled risk of an increased risk of bruising and bleeding. The Pharmacist stated with Voltaren gel being a topical medication the

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F 759	Continued From page 5 risk of it being absorbed systemically and causing an adverse effect was low. An interview conducted on 5/30/24 at 11:56 AM with the Administrator. She said the nurse should follow physician orders when administering medications. She said Nurse #1 should have measured the Voltaren gel before administration.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		6/27/24

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F 761	Continued From page 6 Based on observations, record review, and staff and resident interviews the facility failed to store a medication and left it unattended at the bedside for 1 of 1 resident (Resident #5) reviewed for medication storage. The findings included: Resident #5 was admitted to facility on 5/9/24 with diagnosis that included constipation. A review of the Resident's admission Minimum Data Set (MDS) assessment dated 5/16/24 revealed he was cognitively intact. A review of Resident #5's physician order dated 5/25/2024 revealed he was ordered Senna S Oral Tablet 8.6-50 milligrams (MG). The order continued to give 2 tablets by mouth one time a day for constipation and hold for loose stool. There was no self-administration assessment for any medication in Resident #5's medical record. Review of Resident #5's medical record revealed no care plan for self-administration of medications. On 5/29/24 at 9:29 AM an observation and interview was conducted with Resident #5 in his room. During the interview with Resident #5 was observed to knock over a napkin that contained an orange round pill off his bedside table. The pill was observed to fall to the floor. Resident #5 indicated the orange round pill was from the morning, and it was for his constipation. Resident #5 further indicated he liked to finish his breakfast prior to taking his medication for constipation. He stated that he took the rest of his morning	F 761	F761 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. DON re-educated Nurse #1 on not leaving the medication at the bedside without an order for self-administration. Nurse #1 was educated on Self Administration Policy, and Nurse #1 was re-educated on correct documentation of medication administration on 5/30/2024. Nurse #1 Verbalized understanding of education. Nurse #1 completed Med Pass Fundamentals Video Training 06/08/2024 on Medication Preparation and safety security, Basic route-specific administration, and common errors on oral, ophthalmic, optic, nasal, enteral, topical, inhale, subcutaneous, and suppositories. An audit was conducted of current residents for self-administration orders. On 5/30/24, the facility reviewed care plans and self-administration assessments for identified residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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F 761	Continued From page 7 medication but took his constipation pill later. An interview on 5/29/24 at 9:32 AM with Nurse #1 revealed Resident #5 wanted his stool softener after eating breakfast. Nurse #1 indicated she had left the Senna S Oral tablet on Resident #5's bedside table on purpose so he could take it after breakfast. Nurse #1 also indicated this was a consistent morning routine for Resident #5. An observation with Nurse #1 of Resident #5's Medication Administration Record (MAR) revealed it had been signed on 5/29/24 prior to Resident #5 taking the pill. On 5/29/24 at 2:34 PM the Nurse Supervisor indicated that a nurse should stand and observe a resident taking their medication before leaving the room. The Nursing Supervisor further indicated Nurse #1 should not have left Resident #5's medication at bedside. The MAR should not have been signed due to Resident #5 not consuming the Senna S Oral tablet. An interview was conducted with the Director of Nursing (DON) on 5/29/24 at 3:02 PM. The DON stated Resident #5 should have been observed taking his medication before Nurse #1 left the room. Medication should not be left for residents to take at their discretion. The DON further stated when a resident wanted to take a medication later than the time ordered, the nurse should not sign off on the MAR. The nurse should hold the pill and come back when the resident requests.	F 761	recur. On 6/17/24, DON/Designee completed a medication observation and documentation review with Nurse #1 to ensure compliance was met. Licensed nurses re-educated on the six rights of medication administration (resident, medication, dose, time, route, and documentation) and self-administration policy by DON/Designee by 6/27/24. Newly hired licensed staff will complete education on medication administration protocols and self-administration policy and the DON/Designee will conduct a medication administration observation. Re-education of licensed staff on medication administration protocols, and self-administration policy and medication administration completed by DON/Designee by 6/27/24. Indicate how the facility plans to monitor its performance to make sure that solutions are substantiated. The DON/ Designee will audit weekly for two months, then every other week for two months, and then once a month for two months. The DON/Designee will submit the results of the audits monthly to the Quality Assurance Performance and Improvement (QAPI) Committee Meeting	

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F 761	Continued From page 8	F 761	for six months. Indicate dates when corrective action will be completed The completion of the Plan of Correction is 6/27/24.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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	F 880		6/27/24

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F 880	Continued From page 9 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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, staff, and Nurse Practitioner (NP) interview the facility failed	F 880	F880	

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F 880	Continued From page 10 to wear personal protective equipment (PPE) while administering medications through a peripherally inserted central catheter (PICC line) for a resident requiring Enhanced Barrier Precautions (EBP). This deficit practice occurred for 1 of 2 residents reviewed for EBP (Resident #57). Findings included: Review of the facility's policy and procedure revised on 3/2023, entitled " Policy and procedures guidelines for isolation precautions" read in part: "Enhanced Barrier Precautions (EBP) are used as an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). This precaution expands on the use of PPE and refers to the use of gown and gloves during high-contact resident care activities. That provides opportunities for transfer of MDROs to staff hands and clothing. EBP will be applied to resident with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. Implementation- High-contact care activities that require gown and glove use for Enhanced Barrier Precautions include Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator." Resident #57 was admitted to the facility on 5/13/24. Review of Resident #57 active physician orders for May 2024 revealed he had an order for EBP dated 5/21/24. He had an order dated 5/21/24 that read: Double Lumen PICC to left brachial vein inserted 5/20/24.	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/30/2024, the DON re-educated Nurse #1 on the Enhanced Barrier Precaution (EBP) protocol and required PPE. Nurse #1 verbalized understanding of education. Nurse #1 completed the downing and doffing PPE return demonstration with ADON on 6/12/24. On 6/17/24, DON/Designee completed a medication observation audit to include the observing EBP being followed. An audit was conducted to determine other residents with Enhanced Barrier Precautions Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing staff re-educated on proper protocol for enhanced/barrier precautions and required PPE by DON/Designee by 6/27/24. Newly hired licensed staff will be educated on Enhanced Barrier precautions and	

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	345326	A. BUILDING ______ B. WING ______	05/30/2024

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WILLOWBROOKE COURT SC CTR AT MATTHEWS GLEN	740 PAVILION VIEW DRIVE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 An observation was completed on 5/28/24 at 12:41 PM and revealed Resident #57 had a double lumen PICC line in place to his left upper arm. There was an EBP sign on the outside of his door. There was a cart with PPE supplies including: gowns, mask, and gloves outside the door of his room. An observation was completed on 5/30/24 at 8:50 AM of Nurse #1 accessing Resident #57's PICC line prior to administering his intravenous (IV) medication. The nurse performed hand hygiene using hand sanitizer and donned clean gloves. She did not don a gown. Nurse #1 hung the IV medication on the IV pole and primed the IV tubing. She cleaned the PICC line lumen connection cap with an alcohol swab and connected a flush to the PICC line lumen. An interview was conducted with Nurse #1 on 5/30/24 at 8:58 AM. Nurse #1 stated she was aware that Resident #57 had EBP in place. She explained EPB should be used when providing direct care and changing wound dressings. Nurse #1 stated that if she was providing care for the PICC line or using the PICC line she should use EBP and wear a gown. She stated she had been nervous and forgot to put on the gown. An interview was performed with the Director of Nursing (DON) on 5/30/24 at 9:55 AM. The DON said Nurse #1 should follow EBP guidelines, which included wearing a gown when she accessed the PICC line to administer medications. An interview was performed with the Infection Preventionist (IP) on 5/30/24 at 10:50 AM. The IP stated that residents with indwelling medical	F 880	required PPE by DON/Designee. Medication storage/self-administration, Medication Administration Observation, and EBP observations will be completed as part of the Plan of Correction. Indicate how the facility plans to monitor its performance to make sure that solutions are substantiated The DON/ Designee will audit weekly for two months, then every other week for two months, and then once a month for two months. The DON/Designee will submit the results of the audits monthly to the Quality Assurance Performance and Improvement (QAPI) Committee Meeting for six months. Indicate dates when corrective action will be completed The completion of the Plan of Correction is 6/27/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345326	A. BUILDING ______ B. WING ______	05/30/2024

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F 880	Continued From page 12 devices such as PICC lines should have EBP in place. She said if a nurse was using the PICC line or changing the dressing then they should follow EBP, which included wearing a gown and gloves. An interview was performed with NP on 5/30/24 at 11:00 AM. The NP stated she was aware of EBP being used by the facility. She said Resident #57 had EBP in place for his PICC line and wounds. She stated Nurse #1 should have followed EBP when accessing Resident #57's PICC line. An interview was performed with the Administrator on 5/30/24 at 11:56 AM. She stated if residents have EBP in place, staff should follow the EBP guidelines when performing procedures. The Administrator said Nurse #1 should have followed EBP guidelines and worn a gown when accessing Resident #57's PICC line. She said Nurse #1 did not follow protocol.	F 880		