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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation was conducted on 05/29/24 through 05/30/24. The following intakes were investigated: NC00214455, NC00214537, NC00216009, NC00216506, NC00216429. Event ID: UUGS11.<br><br>3 of the 18 allegations resulted in a deficiency. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, staff and resident interviews, the facility failed to assess residents for the ability to self-administer medications for 2 of 2 residents (Resident #2 and #3) reviewed for self-administering medications.<br><br>The findings include:<br><br>1. Resident #2 was admitted to the facility 10/29/20.<br><br>A review of Resident #2's physician orders revealed orders for Gabapentin Capsule (to treat nerve pain) 300 milligram (mg) give one capsule by mouth three times a day for neuralgia (nerve pain) dated 02/10/22, and Hydrocodone-Acetaminophen (narcotic analgesic) 5/325 mg give one tablet by mouth three times a day for pain dated 02/10/22. There were no orders to self-medicate. | F 554 | • On 5/29/24, Resident #2 took the medications that were left at the bedside.<br><br>• On 5/29/24 the Director of Nursing (DON) assessed resident #2 for self-administration of medications. At that time, the resident indicated they wanted to self-administer medications. Resident #2 was reassessed on 6/18/24 by the DON as the resident had not elected to self-administer medications since 5/29/24. Upon reassessment on 6/18/24 the resident verbalized that he/she no longer wished to self-administer medications.<br><br>• On 5/29/23, Nurse #1 was re-educated on self-administration of medications and that medications are not to be left at bedside for residents who have not been assessed and identified safe to self-administer, have an order and | 6/21/24 |

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

Electronically Signed | 06/21/2024

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| F 554 | Continued From page 1<br>The quarterly Minimum Data Set assessment dated 03/25/24 revealed Resident #2 was cognitively intact.<br><br>A review of Resident #2's medical record revealed there was no assessment to self-administration of medications in the record. There was no care plan developed for the Resident to self-administer medications.<br><br>A review of Resident #2's Medication Administration Record (MAR) for 05/2024 indicated Hydrocodone-Acetaminophen 5/325 mg was given at 12:30 PM on 05/29/24 and Gabapentin Capsule 300 mg was given at 1:00 PM on 05/29/24 and initialed by Nurse #1.<br><br>On 05/29/24 at 2:46 PM an observation and interview were made of Resident #2. Noted on the Resident's over bed table was a medicine cup that had a yellow capsule and a white pill in the cup. The medication was dry and there was no indication that they were in contact with moisture. Resident #2 explained that Nurse #1 brought him the medications and he had not taken them yet, but he would take them in a little while. When asked what they were for the Resident stated one was for his legs and the other was his pain pill.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/29/24 at 2:50 PM who was looking for Nurse #1. The DON was asked if the Nurses were allowed to leave medications on the residents over bed table and she replied, "absolutely not, there are no residents in house that are allowed to self-medicate." The DON was accompanied to Resident #2's room and the Resident was not in his room and the medicine cup was empty. | F 554 | wish to do so. The education also included that residents who have medications in their rooms should be assessed utilizing the Self-Administration of Medications assessment and a physician order should be obtained for residents to self-administer medications. Nurse #1 was removed from her assignment on 5/29/24.<br><br>• On 5/29/24 the DON, educated Resident #2 on the risks of not taking medications as prescribed by the physician to include risks of saving medications and taking at times not recommended by the physician. Resident #2 verbalized understanding.<br><br>• On 5/29/24 the Social Worker (SW) educated resident #3’s family not to bring in outside medications and refer to the nurse for any medication needs. On 5/29/24 the antacid medication was removed from Resident #3 room by the unit manager and returned to Resident #3’s family. Resident #3 declined self -administration of her medications on 5/30/34.<br><br>• On 5/29/24, the unit managers completed an audit of all resident rooms, to ensure medications were not left/stored in the resident’s rooms, unless the resident has been assessed to safely self-administer medications and a physician order is obtained. There were no additional concerns noted.<br><br>• On 5/29/24 the unit manager’s | |

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| F 554 | Continued From page 2<br><br>During an interview with Nurse #1 on 05/29/24 at 3:05 PM the Nurse confirmed that she had medicated Resident #2 earlier and he put the medication in his mouth. She explained that "he must have spit them out after he put them in his mouth". Nurse #1 continued to explain that she gave the Resident his medications at 12:45 PM and she thought he took them.<br><br>On 05/29/24 at 3:45 PM during an interview with the Administrator she explained that the residents were not allowed to self-administer medications unless they had been assessed to be mentally and physically able to self-administer their medications.<br><br>2. Resident #3 re-admitted to the facility on 02/16/24.<br><br>Review of Resident #3's quarterly Minimum Data Set assessment dated 05/22/24 revealed Resident #3 was cognitively intact with no psychosis, behaviors, or rejection of care.<br><br>Review of Resident #3's medical record revealed no documentation that Resident #87 had been assessed to self-administer medications.<br><br>Further review of Resident #3's medical record revealed no care plan for self-administration of medications.<br><br>An observation of Resident #3 completed on 05/29/24 at 10:17 AM revealed her to be in her room, sitting in her wheelchair watching television. On Resident #3's overbed tray was a bottle of antacid chewable tablets. | F 554 | initiated observations of medication administration with all nurses and medication aides. This audit is to ensure the nurse and/or medication aid administered medications following the medication administration rights and to ensure that the nurse and/or medication aid did not leave medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained related to self-administration of medications. The unit managers will address all concerns identified during the audit to include but not limited to the education of staff. The audit will be completed by 6/21/24. After 6/21/24, any nurse or medication aid who has not been observed to complete medication administration will have the audit completed upon the next scheduled work shift.<br><br>• On 5/29/23, the unit managers completed an audit of all resident rooms. This audit is to ensure medications were not left at the resident bedside unless the resident has been assessed to safely self-administer medications and physician order obtained. There were no additional concerns noted.<br><br>• On 6/3/24, the SW initiated interviews with residents that have a BIMS of 13 or greater to ensure any residents wanting to administer their own medications, will be assessed for appropriateness. If found to be appropriate, the Director of Nursing will | |

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| F 554 | Continued From page 3<br>Additional observations made on 05/29/24 at 12:50 PM, 2:44 PM, and 3:00 PM all revealed the antacid chewable tablets remained on Resident #3's overbed table.<br><br>An interview with Nurse #2 on 05/29/24 at 3:58 PM revealed she did not believe that the facility allowed residents to self-administer medications. She reported she knew that none of the residents she cared for on 05/29/23 self-administered medications. Nurse #2 verified she was assigned to care for Resident #3 on 05/29/24 and stated she had not noticed the bottle of antiacid chewable tablets on Resident #3's overbed table. She stated Resident #3 should not have had the bottle of antiacid chewable tablets in her room and reported she would go and remove them and store them on the medication cart where they belonged. Nurse #2 proposed that Resident #4's family had potentially brought the antacid chewable tablets to the facility earlier in the day.<br><br>An interview with Resident #3 on 05/30/24 at 12:10 PM revealed a family member had brought in the antiacid chewable tablets for her the previous day because she complained about some indigestion. She stated she was unaware she was unable to keep them at her bedside and reported that "someone" had removed them from her room. Resident #3 verified she had taken some of the antacid chewable tablets.<br><br>An interview with the Director of Nursing completed on 05/30/24 at 1:24 PM revealed if was not customary for staff to leave medications at resident bedsides. She reported, to her knowledge, there were no residents in the facility that currently had the ability to self-administer medications. She reported the facility's policy | F 554 | institute processes for self-administration of medications. If found not to be appropriate, the Director of Nursing will inform the resident and address any concerns they may have will be addressed.<br><br>• On 5/31/2024, the Staff Development Coordinator (SDC) initiated an in-service for all nurses and medication aids with emphasis on administering medication per physician order and not leaving medication at bedside unless the resident had been assessed to safely self-administer medications and physician order obtained. In-service to be completed on 6/21/2024. After 6/21/2024, nurses and med aids that have not received the in-service will be required to attend in-service prior to their next scheduled shift. All newly hired nurses and/or medication aides will be in-serviced during orientation regarding the self-administration of medication process and ensuring medications are not left at the bedside of residents who have not be assessed to safely self-administer and have a physician's order to do so.<br><br>• An audit of 10 resident rooms will be conducted by SDC/UM/DON weekly x 4 weeks, then monthly x 1 month to ensure medications are not left at the resident's bedside unless the resident has been assessed to safely self-administer medications and physician order obtained. If any medications are noted at the resident's bed side, the medication will be | |

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| F 554 | Continued From page 4<br>required residents to be screened and assessed to ensure they had the cognitive ability to safely administer the medication and keep the medication safe in their room. She indicated that Resident #3 should not have had the antacid chewable tablets in her room for self-administration.<br><br>An interview with the Administrator on 05/30/24 at 1:1 PM revealed she was made aware that Resident #3 had the antacid chewable tablets in her room during a facility-wide audit that was completed after being informed of other medications being found left at resident bedsides. She reported Resident #3 did not have the authority to keep the antacid chewable tablets at her bedside and indicated that Resident #3 had not been assessed to self-administer medications. The Administrator reported the antacid chewable tablets had been removed from Resident #3's room and were being kept in a secure area until Resident #3's family could pick them up. | F 554 | removed, and the resident will be interviewed to determine if they wish to self-administer medications, and if so the process of assessment and obtaining a physician's order will be initiated.<br><br>• The SDC/UM/DON will complete weekly observations of five medication passes x 4 weeks, then monthly x 1 month. This audit is to ensure the nurse and or medication aids administered medications following the rights of medication administration and to ensure that the nurse and/or medication aid did not leave medications at bedside unless the resident had been assessed to safely self-administer medications. If there are areas of concern, observers will ensure appropriate follow up is completed.<br><br>• The Administrator will interview residents newly admitted, with a BIMS of 13 or greater, weekly x 4 weeks then monthly x 1 month to determine if the resident wishes to self-administer their medications. If the resident does wish to self-administer medications an assessment will be completed and the process of obtaining an order will be initiated as appropriate.<br><br>• All concerns identified during the audit to include but not limited to re-education of staff will be addressed.<br><br>• The DON will present the findings of weekly audits to the Quality Assurance Performance (QAPI) committee monthly | |

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| F 554 | Continued From page 5 | F 554 | for 2 months to address any trends, patterns or need for new/changes in current improvement actions. The DON is responsible for ensuring the plan of correction is followed and the Administrator is responsible for ensuring compliance.<br><br>• Date of compliance 6/21/2024 | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and Resident Representative (RR) and staff interviews the facility failed to provide nail care for 2 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #4 and Resident #5).<br><br>The findings included:<br><br>1. Resident #4 was admitted to the facility on 12/11/2014 with diagnoses which included hemiplegia, and muscle weakness. Resident #4 did not have a diagnosis of diabetes.<br><br>A review of the shower schedule for Resident #4 revealed he was scheduled to receive showers on Mondays and Fridays.<br><br>The last documented nail care was on 3/8/2024 and was documented in a nursing progress note. | F 677 | " Resident #5 and Resident #4 were provided nail care by the CNA (Certified Nursing Assistant) on 5/29/2024.<br><br>" On 6/3/24, the nurse consultant audited all residents for nail care. Any resident identified to need nail care will have nail care by the CNA or Nurse.<br><br>" On 5/31/2024, SDC (Staff Development Coordinator) initiated education for nurses and nursing assistants regarding the provision of nail care. This is to ensure nursing assistants know to provide nail care on bath days or to notify nurse if unable to provide needed nail care due to diagnosis. Nurses will be educated to provide nail care if able to do so, if unable to do so due to diagnosis or the status of the nails, the nurse will | 6/21/24 |

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| F 677 | Continued From page 6<br><br>A quarterly Minimum Data Set (MDS) dated 4/2/2024 revealed Resident #4 was severely cognitively impaired with impairment on both sides of the upper and lower extremities. Resident #4 was documented as maximum assist for personal hygiene.<br><br>A review of the care plan dated 4/4/2024 revealed Resident #4 required staff support to achieve the highest practical level of function for activities of daily living with interventions which included Resident #4 required maximal assistance for personal hygiene.<br><br>A review of a shower sheet dated 5/28/2024 revealed Resident #4 received a shower that was scheduled to be performed by NA #4. The space for intervention documentation was blank. There was no documentation regarding fingernails being cut or cleaned.<br><br>An interview was conducted on 5/30/2024 at 9:42 am with NA #4. NA #4 reported she had given Resident #4 a shower on 5/28/2024. NA #4 stated she washed his hair and body but did not cut/clean his fingernails. NA #4 reported she performed nail care when she noticed nails were long and/or dirty but had not noticed Resident #4's nails.<br><br>A telephone interview was conducted on 5/29/2024 at 9:52 am with Resident #4's RR. The RR stated Resident #4 always had long and dirty fingernails when she would come and visit weekly. She reported she had mentioned her concerns in March of 2024 to nursing staff, including the previous Director of Nursing, at the facility, but it continued to be an issue. | F 677 | contact the physician for further orders and/or consultation. Any CNA not attending the in-service by 6/21/2024 will receive the education before their next scheduled shift. The training will be provided to all new hires and agency CNA staff during orientation.<br><br>" The DON (Director of Nursing), UM (Unit Manager), SDC, and Administrator will complete 15 residents nail care audits weekly x 4 weeks, then monthly x 1 month. This audit is to ensure nail care has been provided. The DON/UM/SDC/Administrator will address all areas of concern identified during the audit to include providing care per resident preference and/or training of staff.<br><br>" The DON will forward the results of the nail care audits to the Quality Assurance Performance Improvement Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.<br><br>" Date of Compliance 6/21/2024 | |

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An observation was conducted on 5/29/2024 at 9:57 am. Resident #4 was observed to have contractures of both the left and right hands and had quarter-inch long fingernails, on all ten fingernails on both the right and left hands, with a brown substance underneath. There were 4 of Resident #4's fingernails on the right side that touched his right palm and 4 fingernails on the left side that touched his left palm. There was no redness or open areas observed.

An interview was conducted on 5/29/2024 at 2:43 pm with NA #3. NA #3 was assigned to care for Resident #4 on 5/29/2024. NA #3 reported he had not noticed Resident #4 had long, dirty fingernails. NA #3 stated the shower team usually performed nail care and that he had not cut and cleaned nails at the facility. NA #3 was asked to observe Resident #4's fingernails. NA #3 verbalized Resident #4's fingernails were long and dirty.

An interview was conducted on 5/29/2024 at 2:25 pm with Nurse Aide (NA) #1. NA #1 reported she was on the shower team and was assigned to give showers to residents in the building on their assigned shower days. She reported she had not trimmed or cleaned any residents' fingernails because she was not comfortable cutting nails. NA #1 stated if she noticed a resident's fingernails were long while she was giving them a shower, she would write it down on the shower sheet and tell the hall nurse.

An interview was conducted on 5/29/2024 at 2:38 pm with NA #2. NA #2 reported she was on the shower team and was assigned to give showers to residents according to their shower schedule.

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NA #2 stated she was not responsible for cutting fingernails or toenails and was unsure of who was. NA #2 reported if she noticed a resident had long nails she would report it to the Nurse.

An interview was conducted on 5/29/2024 at 3:11 pm with the Staff Development Coordinator (SDC). The SDC reported nursing staff, both NAs and Nurses, were trained about nail care during orientation. The SDC stated both NAs and Nurses were responsible for cutting and cleaning fingernails unless the resident had a diagnosis of diabetes. The SDC stated all staff were trained to cut and clean dirty nails. The SDC reported nail care was to be performed whenever a resident had long or dirty nails regardless if it was the resident's shower day or not. The SDC was not aware if anyone audited nail care in the facility.

An interview was conducted on 5/30/2024 at 8:30 am with the Unit Manager. The Unit Manager stated staff had been educated in March of 2024 regarding nail care, including cutting and cleaning. The Unit Manager stated NAs and Nurses could cut and clean nails unless the resident had a diagnosis of diabetes. She reported for residents with a diagnosis of diabetes a podiatry consultation would need to be placed. The Unit Manager was unsure if anyone monitored nail care for the residents.

An interview was conducted on 5/30/2024 at 11:43 am with the Director of Nursing (DON). The DON reported nail care should be performed daily and as needed. The DON stated NAs usually cut and cleaned resident's fingernails. The DON reported she was not aware Resident #4 had long, dirty fingernails and reported they should have been cleaned and cut. The DON

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was unaware if anyone monitored nail care for the residents.

An interview was conducted on 5/30/2024 at 11:51 am with the Administrator. The Administrator stated nail care should be performed daily by the hall NAs or as needed. The Administrator stated a lot of staff were not comfortable with cutting fingernails. The Administrator stated if an NA was not comfortable with cutting nails, they should let a Nurse know so someone would perform the task. The Administrator was not aware Resident #4 had long, dirty fingernails.

2. Resident #5 was admitted to the facility on 5/13/2024 with diagnoses which included vascular dementia. Resident #5 did not have a diagnosis of diabetes.

An admission Minimum Data Set (MDS) dated 5/20/2024 revealed Resident #5 was severely cognitively impaired and required substantial/maximum assistance for personal hygiene.

A review of the shower schedule for Resident #4 revealed he was scheduled to receive showers on Tuesdays and Fridays.

There was no documentation of nail care in the Electronic Medical Record or shower sheets.

A review of the shower sheet dated 5/24/2024 revealed Resident #5 received a shower by NA #1. The space for intervention documentation was blank. There was no documentation of Resident #5's fingernails being cut or cleaned.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345142 | A. BUILDING _____ B. WING _____ | C 05/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNIVERSITY PLACE NURSING AND REHABILITATION CENTER | 9200 GLENWATER DRIVE CHARLOTTE, NC 28262 |

| (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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| F 677 | Continued From page 10 | F 677 | | |

A review of a care plan dated 5/27/2024 revealed Resident #5 required staff support to achieve highest practical level of function for activities of daily living with interventions which included Resident #5 required substantial/maximum assistance for personal hygiene.

An observation was conducted on 5/29/2024 at 10:13 am. Resident #5 was observed to have quarter-inch long fingernails with brown substance underneath all 5 fingernails on the left hand and 4 fingernails on the right hand. Resident #5's right thumb fingernail was approximately a half-inch long, jagged, and had a brown substance underneath.

An interview was conducted on 5/29/2024 at 2:25 pm with Nurse Aide (NA) #1. NA #1 reported she was on the shower team and was assigned to give showers to residents in the building on their assigned shower days. NA #1 reported she had given Resident #5 a shower on 5/28/2024 and she had not noticed that her fingernails were long and dirty. She reported she had not trimmed or cleaned any residents fingernails because she was not comfortable cutting nails. NA #1 reported she would clean resident's fingernails during a shower if she had noticed they were dirty. NA #1 stated if she noticed a resident's fingernails were long while she was giving them a shower, she would write it down on the shower sheet and tell the hall nurse.

An interview was conducted on 5/29/2024 at 3:11 pm with the Staff Development Coordinator (SDC). The SDC reported nursing staff, both NAs and Nurses, were trained about nail care during orientation. The SDC stated both NAs and Nurses were responsible for cutting and cleaning

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fingernails unless the resident had a diagnosis of diabetes. The SDC stated all staff were trained to cut and clean dirty nails. The SDC reported nail care was to be performed whenever a resident had long or dirty nails regardless if it was the resident's shower day or not. The SDC was not aware if anyone audited nail care in the facility.

An interview was conducted on 5/30/2024 at 8:30 am with the Unit Manager. The Unit Manager stated staff had been educated in March of 2024 regarding nail care, including cutting and cleaning. The Unit Manager stated NAs and Nurses could cut and clean nails unless the resident had a diagnosis of diabetes. She reported for residents with a diagnosis of diabetes a podiatry consultation would need to be placed. The Unit Manager was unsure if anyone monitored nail care for the residents.

An interview was conducted on 5/30/2024 at 11:43 am with the Director of Nursing (DON). The DON reported nail care should be performed daily and as needed. The DON stated NAs usually cut and cleaned resident's fingernails. The DON reported she was not aware Resident #5 had long, dirty fingernails and reported they should have been cleaned and cut. The DON was unaware if anyone monitored nail care for the residents.

An interview was conducted on 5/30/2024 at 11:51 am with the Administrator. The Administrator stated nail care should be performed daily by the hall NAs or as needed. The Administrator stated a lot of staff were not comfortable with cutting fingernails. The Administrator stated if an NA was not comfortable with cutting nails, they should let a Nurse know so

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| F 677 | Continued From page 12<br>someone would perform the task. The Administrator was not aware Resident #5 had long, dirty fingernails. | F 677 | | |