STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345467	A. BUILDING _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVANT HEALTH PRESBYTERIAN MEDICAL CENTER-SNU	200 HAWTHORNE LANE CHARLOTTE, NC 28207

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 8/12/2024 through 8/15/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #COCH11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted 8/12/2024 through 8/15/2024. Event ID# COCH11.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to apply signage indicating the use of oxygen outside the resident's room for 2 of 2 residents reviewed for oxygen use (Resident #9 and Resident #5). The findings included: 1. Resident #9 was admitted on 7/24/24 with diagnoses of chronic obstructive pulmonary disease. Review of the admission Minimum Data Set (MDS) assessment dated 7/25/24 indicated	F 695	D F695 On 8/12/24 oxygen in use signage was posted on the doors of Resident #9 and Resident #5. On 8/12/24 the Administrator reviewed all residents on the skilled nursing unit (SNU) for orders for oxygen. Only Resident #5 and #9 had oxygen orders and oxygen in use signage was posted as needed. The Administrator also reviewed the unit par to ensure there were enough oxygen in se	9/10/24

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

Electronically Signed | 09/06/2024

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F 695	Continued From page 1 Resident #9 was cognitively intact and coded for the use of oxygen. A physician's order for Resident #9 dated 7/25/24 for 2 liters per minutes (LPM) oxygen continuous via nasal cannula. During an observation on 8/12/24 at 12:05 pm no signage for oxygen use was to be found anywhere near to resident's room entrance. Resident #9 was observed wearing her oxygen via a nasal canula at 2LPM. The oxygen concentrator was observed on the right side of the bed in Resident #9's room. Interview with the Accreditation and Regulatory staff member #1 on 8/12/24 at 2:00 pm stated they were not required to post No Smoking signs on the doors of the residents using oxygen as they were a smoke-free facility. The Accreditation and Regulatory staff member #1 stated they were only required to place a sign informing the public that they were a smoke-free facility in prominent areas. The Accreditation and Regulatory staff member #1 referred to the Fire Protection Association literature dated 8/12/24 which read in part: In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required. Interview with Nurse #1 on 8/13/24 at 12:40 pm revealed that Novant Health campus was a smoke-free facility. This was inclusive of the skilled unit. Nurse #1 continued to explain per facility policy they were not required to post the no smoking signs on the resident's doors.	F 695	signage for each resident room if needed. As of 9/4/24 the New Admission checkoff list was revised to include a review of Oxygen orders and confirmation of placement of oxygen in use signage at the room door. Administrator and/or designee conducted a daily audit in the month of August of all new admissions for Oxygen orders to make certain signage of cautionary indicating the use of oxygen were posted. As of 8/30/24 100% of SNU team members were educated on the intention of requirement ¿483.25 (i) which includes posted signage of cautionary indicating the use of oxygen, by the Administrator and/ or designee. Training for professional and support services team members such as rehabilitative services and resource nursing will be educated by 9/10/24 on the requirements for oxygen signage posting. A weekly audit of oxygen signage will be completed x 2 months and then biweekly x 3 months. All results from auditing and monitoring will be taken to QAPI quarterly and reviewed by the QAA Committee for any ongoing needs. The administrator of the skilled nursing unit is ultimately responsible for the corrective action plan and ongoing/sustained compliance with the corrective action plan.	

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F 695	Continued From page 2	F 695		

On 8/13/24 at 3:00 pm an interview with the Director of Accreditation and Regulatory was completed who stated they were a smoke-free facility and there were general "No Smoking" signs in the parking lot and several entrances before entering the building. The Director of Accreditation and Regulatory continued to explain the Patient Handbook was provided which informs the patients for their health and wellness, Novant Health was a tobacco free organization. The Director of Accreditation and Regulatory also stated the same information was available on the patient's online record access.

On 8/15/24 at 10:59 am an interview with the Administrator revealed the facility was in the hospital environment and there was some confusion with staff about posting no smoking signs at the resident's door. The Administrator stated the hospital followed the National Fire Prevention regulation which indicated oxygen signage was not required at the resident's room door.

2. Resident #5 was admitted to the facility on 7/23/24 with diagnoses of Tachypnea (crackling in the lungs).
Review of the admission Minimum Data Set (MDS) assessment dated 7/23/24 indicated Resident #5 was cognitively intact and coded for the use of oxygen.

A physician's order for Resident #5 dated 7/24/24 for 2 liters per minutes (LPM) oxygen continuous via nasal cannula.

During an observation on 8/12/24 at 12:37 pm, there was no signage outside Resident #5's room indicating the usage of oxygen. Resident #5 was

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F 695	Continued From page 3	F 695		

observed wearing her oxygen via nasal cannula at 2 LPM. The oxygen concentrator was observed on the right side of the bed in Resident #5's room.

Interview with the Accreditation and Regulatory staff member #1 on 8/12/24 at 2:00 pm stated they were not required to post No Smoking signs on the doors of the residents using oxygen as they were a smoke-free facility. The Accreditation and Regulatory staff member #1 stated they were only required to place a sign informing the public that they were a smoke-free facility in prominent areas. The Accreditation and Regulatory staff member #1 referred to the Fire Protection Association literature dated 8/12/24 which read in part: In health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required.

Interview with Nurse #1 on 8/13/24 at 12:40 pm revealed that Novant Health campus was a smoke-free facility. This was inclusive of the skilled unit. Nurse #1 continued to explain per facility policy they were not required to post the no smoking signs on the resident's doors.

On 8/13/24 at 3:00 pm an interview with the Director of Accreditation and Regulatory was completed who stated they were a smoke-free facility and there were general "No Smoking" signs in the parking lot and several entrances before entering the building. The Director of Accreditation and Regulatory continued to explain the Patient Handbook was provided which informs the patients for their health and wellness, Novant Health was a tobacco free organization. The Director of Accreditation and Regulatory also

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F 695	Continued From page 4 stated the same information was available on the patient's online record access. On 8/15/24 at 10:59 am an interview with the Administrator revealed the facility was in the hospital environment and there was some confusion with staff about posting no smoking signs at the resident's door. The Administrator stated the hospital followed the National Fire Prevention regulation which indicated oxygen signage was not required at the resident's room door.	F 695		
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 and staff interviews, the facility failed to maintain a medication error rate of 5% or less as evidenced by 2 medication errors out of 26 opportunities. This resulted in a medication error rate of 7.69% for 1 of 3 residents (Resident #1) observed during medication administration observation. The findings included: A physician order dated 08/12/24 revealed Resident #1 was to receive tamsulosin (Flomax) capsule 0.4 milligrams (mg) daily for acute urinary retention and pantoprazole sodium (Protonix) EC (enteric coated) tablet 40mg daily for acid reflux. Administration instructions for both medications	F 759	D F759 On 8/14/24 the Administrator notified the Medical Director (MD) of Resident #5□s medications that were indicated as do not crush, were crushed. The MD confirmed the medications would have not caused harm if crushed. On 8/15/24 the MD discontinued Tamsulosin and ordered Cardura which is a crushable alternative. On 8/14/24 Pantoprazole was discontinued. Resident #5 was discharged to the hospital on 8/15/24 for a previously scheduled test. On 8/14/24 the Administrator reviewed all	9/10/24

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F 759	Continued From page 5 were: Do not open or crush. During the medication pass observation on 08/14/24 at 9:14 AM: 1a. Nurse #2 prepared medications for Resident #1. Nurse #2 was observed taking a pantoprazole sodium EC tablet 40mg out of a blister package and used a pill-crushing device to crush the medicine. Nurse #2 proceeded to sprinkle the medication into the apple sauce. 1b. Nurse #2 was observed to twist open a tamsulosin capsule 0.4mg and sprinkle this medication into the apple sauce. At 9:16 AM, Nurse #2 administered the pantoprazole sodium EC tablet 40mg and tamsulosin capsule 0.4mg with apple sauce to the resident. An interview with Pharmacist #1 and Pharmacist #2 on 08/14/24 at 10:25 AM revealed that pharmacy has the ability to substitute medications if they were aware. Pharmacist #1 stated the tamsulosin would have a rapid onset of action if opened and given to the resident in applesauce for consumption. Pharmacist #1 further stated the pantoprazole sodium EC should not have been crushed unless indicated by the physician. Both Pharmacist #1 and Pharmacist #2 verbalized the pharmacy did not get any requests from the skilled nursing unit to provide alternative medication substitutes for the tamsulosin and pantoprazole sodium EC or a physician's order clarifying the administration directions for the two medications to be crushed and or opened. An interview with Nurse #2 on 08/14/24 at 4:47	F 759	residents on the skilled nursing unit (SNU) with orders for medications that could not be crushed to make sure the resident□s receiving the medication did not require medications to be crushed. No other residents required medications to be crushed. On 8/30/24 the Administrator and/ or designee educated 100% of the SNU team members on the medication error and the requirements to follow MD orders. This education also included steps nursing should take to obtain alternative medications when medication is ordered. Training for appropriate professional and support services team members will be completed by 9/10/24 on the requirements for medication administration of non-crushable medications. Two medication administration audits will be conducted weekly x 1 month; then 1 per week x 3 months and then a random audit of medication administration x 3 months for a total of 6 medication administration adults to ensure team members are following medication administration orders/ guidelines as per MD order. All results from auditing and monitoring will be taken to QAPI quarterly and reviewed by the QAA Committee for any ongoing needs. The administrator of the skilled nursing unit is ultimately responsible for the corrective action plan and ongoing compliance with the corrective action plan.	

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F 759	Continued From page 6 PM revealed administration instructions were displayed on the Electronic Medication Administration Record (eMAR) under details. Nurse #2 explained she had no particular reason why she did not read the administration instructions when preparing the medications for Resident #1. An interview with the Administrator on 08/14/24 at 4:54 PM stated that Nurse #2 should have reached out to the physician or pharmacy to determine if there were alternative medicines and not have disregarded the administration directions for the medications to not be crushed or not opened.	F 759		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep the area around the garbage compacter free of accumulated trash and debris for 1 of 1 garbage compacter observed. The findings included: A continuous observation was completed of the garbage compacter area on 8/12/2024 from 4:07 PM to 4:15 PM. The observation revealed the following items outside of the garbage compacter: 1 bag of trash, 3 to 4 used disposable gloves, 1 medium clear plastic bag with 4 exposed bread slices on the ground, 1 large cardboard box that was flat. The area was observed to be malodorous and had a lingering foul/ sour smell.	F 814	F814 On 8/12/24 the director of operations immediately met with the director of food and nutrition and environmental services to discuss the observation of non-compliance with the trash compactor. On 8/12/24 the director of operations had the dock area around the trash compactor thoroughly cleaned to remove all debris and trash On 8/12/24 the director of operations required director of food and nutrition, and environmental services to educate 100%	9/10/24

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F 814	Continued From page 7 There was wet, thick blackish/ brownish sludge matter observed around the area of the garbage compacter. At 4:15 PM an unknown staff member was observed operating the riser to the garbage compacter. While the riser was in motion and lifting, there was debris and black/brown sludge observed underneath the rising mechanism. There were 2 to 3 garbage bags filled with miscellaneous items observed behind the riser and in between the compacter. Soiled plastic gloves were on the ground around this area along with other unidentifiable items observed in the sludge. Flying insects were observed around the area of the garbage compacter. An interview was completed on 8/12/2024 at 4:10 PM with the Resident Regional Environmental Service Director who explained the garbage compacter area was a shared duty between environmental services and dietary. He explained Environmental Services would clean the area in the mornings and the afternoon/evenings. The area would also be spot checked throughout the day by Environmental Services. He did not provide a frequency or time for the spot checking of the area. An interview was completed on 8/12/2024 at 4:13 PM with the Environmental Services Director who stated environmental services staff should check the garbage compacter area two times daily. He further stated spot checks should also be completed throughout the day by environmental services staff. He did not provide a frequency or time for the spot checking of the area. The Environmental Services Director did state he last checked the area around 9:30 AM and observed a clear plastic bag on the ground in the garbage	F 814	of the team members with job duties involving the compactor/dock on keeping the area free of debris or trash. By 8/16/24 100% of team members with job duties involving the compactor/dock (within food and nutrition and environmental services) were educated on keeping the dock around the trash compactor free of debris or trash. Roster was obtained. On 8/12/24 all new team members will be educated on compactor/dock environmental maintenance and safety through the orientation and onboarding process. On 8/12/24 the director of operations required director of food and nutrition, and environmental services to educate 100% of the team members with job duties involving the compactor/dock on keeping the area free of debris or trash. By 8/16/24 100% of team members with job duties involving the compactor/dock (within food and nutrition and environmental services) were educated on keeping the dock around the trash compactor free of debris or trash. Roster was obtained. On 8/12/24 all new team members will be educated on compactor/dock environmental maintenance and safety through the orientation and onboarding process.	

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F 814	Continued From page 8 compacter area that remained present during the surveyor and staff observation. An interview was completed with the Director of Operations on 8/14/2024 at 3:46 PM. She revealed Environmental Services and Food/ Nutrition Services should maintain the cleanliness of the garbage compacter area. This responsibility was a shared responsibility between the two departments. Going forward this area would be cleaned monthly via an external contracture as well as an audit tool would be implemented to see clear follow up from internal staff to ensure the area remained clean. An interview with the Administrator was completed on 8/14/2024 at 3:57 PM. She revealed there should be clear communication between Environmental Services and Food/ Nutrition Services to maintain the cleanliness of the area around the garbage compacter.	F 814	By 8/16/24 100% of team members with job duties involving the compactor/dock (within food and nutrition and environmental services) were educated on keeping the dock around the trash compactor free of debris or trash. Roster was obtained. The environmental services leadership team is conducting 3 audits daily (1 per shift) for 90 days with a goal of 100% sustained compliance. The food and nutrition services leadership team is conducting one audit daily for 90 days with a goal of 100% sustained compliance. The Director of operations is ultimately responsible for the corrective action plan and ongoing compliance with the corrective action plan. All results from auditing and monitoring will be taken to QAPI quarterly and reviewed by the QAA Committee for any ongoing needs.	