STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKWELL PARK REHABILITATION AND HEALTHCARE CENTER	1930 WEST SUGAR CREEK ROAD 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
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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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E 013	Continued From page 1 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement their Emergency Preparedness (EP) plan for fire emergencies when a small fire occurred in a resident's room and the staff failed to activate the fire alarm. This deficient practice had the potential to affect all residents. The findings included: A review of the Emergency Preparedness plan provided by the facility revealed the plan was reviewed and updated by the Administrator on 1/28/2025. The facility's procedure in the event of	E 013	Past noncompliance: no plan of correction required.	

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a fire was for staff to implement Rescue, Alarm, Contain and Extinguish/Evacuate (RACE) which included rescuing anyone in immediate danger of the fire, activating the nearest fire alarm and then calling 911, containing the fire by closing all doors, and extinguishing small fires or evacuating the area if the fire could not be extinguished.

A fire incident report dated 4/09/25 completed by the Administrator indicated on 4/07/25 a fire was detected by staff in a resident's room and staff removed the resident from the room, notified the fire department by calling 911, and successfully extinguished the fire. There were no staff or residents injured.

An observation conducted on 5/21/25 at 9:00 AM indicated a fire alarm pull station was located at the main door to the facility, approximately 75 feet from Resident #59's room and was the closest fire alarm pull station.

An interview was conducted with Nurse Aide (NA) #3 on 5/21/25 at 9:30 AM. She stated on 4/07/25 at approximately 10:45 PM she heard Resident #59 yelling "fire" and smelled smoke. NA #3 indicated she immediately responded to Resident #59's room, removed him from the room and started yelling "fire" to alert other staff. NA # 3 stated she brought Resident #59 to the lobby at the front entrance to the facility. She revealed Nurse #3 called 911 and instructed staff to close the doors to the other residents' rooms on the hall where the fire was located. NA #3 stated she returned to Resident #59's room with NA #4 and she used a fire extinguisher to put out the fire prior to the fire department arriving. She stated Resident #59 did not have a roommate and did not use oxygen. NA #3 indicated there was some

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E 013	Continued From page 3	E 013		

smoke, but it did not cause the smoke detectors to alarm and the sprinkler system was not activated. NA #3 revealed there is a fire alarm pull station at the front entrance to the facility, however she panicked and forgot to pull the fire alarm.

Several attempts made to contact NA #4 were unsuccessful.

During a phone interview with Nurse #3 on 5/20/25 at 4:15 PM she indicated on 4/07/25 at approximately 10:45 PM she was administering residents' medications when she heard staff yelling there was a fire. She stated she instructed staff to close the doors to the other residents' rooms on the hall where the fire was located and then called 911. She stated NA #4 used a fire extinguisher to put out the fire and the fire department arrived within a few minutes. Nurse #3 indicated there was some smoke, but it did not activate the smoke detectors or the sprinkler system. Nurse #3 revealed she was focused on calling 911 and checking on Resident #59 and did not pull and activate the fire alarm. She stated she was aware of where fire alarm pull stations were located, including one at the front entrance but did not think about activating it when the incident occurred.

An interview with the Director of Maintenance on 5/22/25 at 8:24 AM revealed on 4/07/25 there was a small fire in a resident's room and staff implemented the RACE procedure but failed to activate the fire alarm. He stated activating the facility's fire alarm was important because it notified everyone in the building there was a fire, closed all fire doors to help contain the fire and shut down the heating, ventilation and air

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E 013	Continued From page 4	E 013		

conditioning (HVAC) system which also helped prevent the fire and smoke from spreading. He stated he started working at the facility on 4/04/25 and would be responsible for providing fire safety training including RACE to new employees and annually for all staff and would also conduct the monthly fire drills however he had not provided the education prior to the fire on 4/07/25. The Director of Maintenance revealed that staff reported after the incident that they were "panicked" and forgot to activate the fire alarm.

During an interview with the Administrator on 5/21/25 at 5:01 PM he stated on 4/07/25 there was a small fire in a resident's room that was contained to the light fixture and staff were able to use a fire extinguisher to put out the fire prior to the fire department arriving. He revealed there was no structural damage from the fire and no residents or staff were injured. The Administrator stated that during the incident on 4/07/25 staff implemented the RACE procedure but failed to activate the fire alarm. He indicated activating the fire alarm notified everyone in the building there was a fire, notified the fire department, closed all the fire doors and shutdown the HVAC system to prevent fire and smoke from spreading. He stated staff reported after the incident they panicked and forgot to pull and activate the alarm. The Administrator revealed he completed Emergency Preparedness Training for all staff on 1/31/25 and 2/4/25 which included implementing the RACE procedure during a fire emergency.

The facility provided the following corrective action plan:

Address how corrective action will be accomplished for those residents found to have

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E 013	Continued From page 5 been affected by the deficient practice. On 4/7/25, there was a small fire in Resident #1's room which was at the source of the overbed light. Staff responded immediately, removed Resident #1 from the room and extinguished the fire however they did not pull and activate the fire alarm system. The fire and smoke were contained to Resident #1's room. Resident #1 was assessed by Emergency Medical Services (EMS) and the Director of Nursing (DON) on 4/07/25 and no injuries were noted. Resident #1 was moved to another room following the incident. Resident #1 was assessed by the Nurse Practitioner on 4/08/25 and on 4/09/25, and no injuries were noted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/7/25, all residents that resided on the unit where the fire occurred were checked by EMS and the DON. No injuries or areas of concern were noted. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not occur. On 4/7/25, the staff who were working were immediately educated on RACE and the procedure for using the fire extinguisher PASS (Pull, Aim, Squeeze and Sweep), by the Director of Nursing. The Director of Nursing, the Assistant Director of Nursing, and the Director of Maintenance educated all staff on 4/8/25 and 4/9/25 on RACE and PASS. Staff not educated on 4/8/25 or 4/9/25 were educated by the Director of	E 013		

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Nursing prior to the start of their next scheduled shift. The Director of Maintenance was notified by the Administrator that starting on 4/09/25 he would be responsible for providing RACE and PASS training for all newly hired staff during orientation and will also conduct monthly fire drills on alternating shifts which will include RACE and PASS training at the completion of each fire drill.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action plan will be completed.

A Quality Assurance Performance Improvement (QAPI) committee meeting was held on 4/08/25 to discuss the fire incident on 4/07/25.

Starting on 4/09/25, monthly audits will be conducted by the Director of Maintenance during the monthly fire drills to ensure RACE and PASS procedures are followed by staff. The audits will be ongoing with no end date and the audit results will be reviewed by the QAPI committee during the monthly meetings to determine if further actions are needed.

The facility's alleged date of compliance is 4/10/25.

Validation of the facility's corrective action plan was conducted on 5/21/25 which included record review and staff interviews. An interview conducted with the Director of Nursing revealed on 4/07/25 she provided education on RACE and PASS to the nursing staff that were working when the fire occurred, and all staff had received the education by 4/09/25. Interviews conducted with nursing, dining, maintenance and housekeeping

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E 013	Continued From page 7 staff revealed education was provided on RACE and PASS and they have participated in monthly fire drills. An interview conducted with the Director of Maintenance indicated RACE and PASS education was added to the monthly fire drill and provided to staff following the drills. The Director of Maintenance revealed starting 4/09/25 he started auditing the fire drills to ensure staff follow the RACE and PASS procedures and completes a checklist that each step was completed. A review of the education sign-in-sheets dated 4/07/25, 4/08/25 and 4/09/25 indicated staff had received education on RACE and PASS. A review of the fire drill audits indicated the Director of Maintenance was completing the audits monthly and all steps of RACE and PASS were checked off as completed by staff during the fire drill with no concerns identified. The facility's corrective action plan completion date of 4/10/2025 was validated.	E 013		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted 5/19/2025 through 5/22/2025. Additional information was obtained offsite on 5/23/2025. Therefore, the exit date was changed to 5/23/2025. Event ID# 296E11. The following intakes were investigated NC00229686 and NC00227712. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 628 SS=C	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii)	F 628		6/18/25

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F 628	Continued From page 8 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 628		

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accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

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F 628	Continued From page 12 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on record review and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of the resident's transfer and discharge to the hospital for 1of 2 residents reviewed for hospitalization (Resident #150). The findings included: Resident was admitted to the facility on 3/18/2025. A nursing note dated 4/13/2025 at 6:51 PM stated Resident #150 was transferred to the hospital for further workup of lack of appetite and generalized weakness. A nursing note dated 4/18/2025 at 2:37 PM indicated Resident #150 was readmitted to the facility. A nursing note dated 4/28/2025 at 6:26 PM stated Resident #150 was transferred to the hospital due	F 628	On 6/9/25 the Social Service Director notified the Ombudsman of resident #150 transfers to the hospital for 4/13/2025 and 5/15/2025. All residents requiring hospital transfers or discharges have the potential to be affected. On 6/9/2025 the Social Service Director completed a 100% audit of all residents transferred to the hospital or discharged for the last 90 days and notification to the Ombudsman was completed for all transfers and discharges on 6/9/2025. The Director of Nursing educated the Social Service Director on the requirements for Ombudsman notification for all hospital transfers and discharges from the facility. This was completed on 5/23/25. This	

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	345489	A. BUILDING _____ B. WING _____	C 05/23/2025

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F 628	Continued From page 13 to urinary retention. A nursing note dated 5/15/2025 at 4:15 PM indicated Resident #150 was readmitted to the facility. An interview on 5/22/2025 at 11:38 AM with the Ombudsman revealed she did not receive a hospital transfer and discharge list for April 2025. An interview on 5/22/2025 at 9:36 AM with the Director of Nursing (DON) indicated that Resident #150 had been transferred to the hospital several times since her admission to the facility. She indicated social work was responsible for communicating information to the Ombudsman regarding hospital transfers and discharges. An interview on 5/22/2025 at 11:56 AM with Social Worker (SW) #1 revealed she was unaware that information regarding hospital transfers and discharges was to be provided to the Ombudsman. SW #1 indicated this requirement had never been mentioned to her during her training. She stated she had not sent any transfer or discharge lists to the Ombudsman since the start of her employment in February 2025. She stated no one at the facility was currently sending the transfer/discharge list to the Ombudsman. An interview on 5/22/2025 at 1:11 PM with the Administrator revealed that the SW was responsible for notifying the Ombudsman of hospital transfers and discharges. He stated he had become aware today that social work had not been providing the hospital transfer and discharge list to the Ombudsman. He did not understand how this requirement had been	F 628	education will be added to the facility orientation program for all newly hired Social Service employees. The Director of Nursing/Designee will audit all hospital transfers and discharges from the facility weekly for 12 weeks to ensure proper notification to the Ombudsman. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 628	Continued From page 14 missed as he had sent SW #1 to other nursing facilities to train with other social workers. The Administrator stated the hospital transfer and discharge list should be sent to the Ombudsman each month.	F 628		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 641		6/18/25

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F 641	Continued From page 15 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge status (Resident #98), Preadmission Screening and Resident Review (PASRR) (Resident #76), falls (Resident #54), and physical restraints (Resident #73). This deficient practice occurred for 4 of 19 residents reviewed for accuracy of assessments. The findings included: 1. Resident #98 was admitted to the facility 6/15/23 and discharged from the facility 4/10/25. The facility discharge summary dated 4/10/25 revealed Resident #98 was discharged to an Assisted Living Facility (ALF). The discharge MDS assessment dated 4/10/25 indicated Resident #98's discharge was unplanned, initiated by the facility and return was not anticipated. Resident #98's discharge location was coded short-term hospital. During an interview with MDS Coordinator #1 on 5/21/25 at 3:46 PM he revealed when a resident was discharged from the facility, he reviewed the electronic medical record and/or communicated with staff to determine the resident's discharge location prior to completing the MDS. He stated Resident #98 was discharged to an ALF on 4/10/25. MDS Coordinator #1 indicated Resident #98's discharge location coded short term hospital was inaccurate and an oversight on his part. An interview with the Director of Nursing on 5/22/25 at 3:59 PM indicated Resident #98 was discharged to an ALF and the MDS assessment	F 641	Resident #98s Minimum Data Set (MDS) for 4/10/2025 was corrected on 5/21/2025 to reflect accurate discharge status. Resident #76s Minimum Data Set (MDS) for 1/2/2025 was corrected on 5/22/2025 to reflect accurate Level II PASRR. Resident #54s Minimum Data Set (MDS) for 4/26/2025 was corrected on 5/22/2025 to reflect accuracy of falls. Resident #73s Minimum Data Set (MDS) for 3/16/2025 was corrected on 5/21/2025 to reflect that resident does not utilize bed rails. The Regional Director of Clinical Reimbursement completed a 100% audit for all Minimum Data Set (MDS) for the last 30 to ensure accuracy of coding for all discharge status, Level II PASRRs, accuracy of falls and utilization of bed rails. Any issues were immediately corrected. This audit was completed on 6/16/2025 The Regional Director of Clinical Reimbursement re-educated the Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) assistant on coding the MDS accurately. Re-education was completed on 5/22/2025. This education will be added to the facility orientation program for newly hired Minimum Data Set (MDS) employees. The Regional Director of Clinical	

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F 641	Continued From page 16 should have been coded with an accurate discharge location. An interview conducted with the Administrator on 5/22/25 at 4:24 PM revealed resident MDS assessments should be coded accurately. 2. Resident #76 was admitted to the facility on 02/02/23 with diagnoses which included schizophrenia. A Pre-Admission Screening and Resident Review (PASRR) dated 05/24/24 revealed Resident #76 was determined to be a level II PASRR (a person having or suspected of having a PASRR condition such as serious mental illness, intellectual disability or developmental disability). Review of the annual Minimum Data Set (MDS) assessment dated 01/02/25 for Resident #76 revealed she was moderately cognitively impaired. Under the section for PASRR Resident #76 was coded as not being a level II. An interview conducted on 05/22/25 at 12:12 PM with MDS Coordinator #1 at the facility revealed he had just started at the facility in April of 2025 and was not at the facility when the annual MDS was completed. MDS Coordinator #1 stated the resident was a level II PASRR and should have been coded for it on the MDS assessment. MDS Coordinator #1 further stated he would modify the assessment and resubmit. An interview on 05/22/25 at 12:25 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident.	F 641	Reimbursement/designee will audit 10 Minimum Data Set (MDS) assessments weekly for 12 weeks to ensure accuracy of coding for discharges, falls, Level II PASRRs and utilization of bed rails. The Regional Director of Clinical Reimbursement or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 641	Continued From page 17	F 641		

An interview on 05/22/25 at 1:54 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions.

3. Resident #54 was admitted to the facility on 05/06/22 with diagnoses which included orthostatic hypotension.

An incident report dated 12/29/24 at 10:31 PM revealed Resident #54 had experienced an unwitnessed fall and was found sitting on the floor in her room yelling for help. No injuries were noted at the time of the fall.

An incident report dated 03/18/25 at 12:30 AM revealed Resident #54 had experienced a witnessed fall in her room by nursing staff. No injuries were noted at the time of the fall.

Review of the quarterly Minimum Data Set (MDS) assessment dated 04/26/25 for Resident #54 revealed she was severely cognitively impaired. Under the section for fall history since admission, entry or reentry Resident #54 was coded as having experienced no falls since admission into the facility.

An interview conducted on 05/22/25 at 12:12 PM with MDS Coordinator #1 at the facility revealed he had just started at the facility in April of 2025. MDS Coordinator #1 stated looking back at Resident #54's nursing progress notes she had experienced several falls and should have been coded for it on the MDS assessment. MDS Coordinator #1 further stated he would modify the assessment and resubmit.

An interview on 05/22/25 at 12:25 PM with the

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F 641	Continued From page 18	F 641		

Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident.

An interview on 05/22/25 at 1:54 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions.

4. Resident #73 was admitted to the facility on 08/16/22 with diagnoses which included cerebrovascular accident (CVA).

Review of the quarterly Minimum Data Set (MDS) assessment dated 03/16/25 for Resident #73 revealed he was unable to complete the cognition portion of the assessment. Under the section for physical restraints, Resident #73 was coded for use of bed rails.

Resident #73 was observed on 05/19/25 at 11:13 AM lying in bed. No bed rails were observed on Resident #73's bed.

Resident #73 was observed on 05/21/25 at 10:42 AM lying in bed. No bed rails were observed on Resident #73's bed.

An interview conducted on 05/22/25 at 12:12 PM with MDS Coordinator #1 at the facility revealed he had just started at the facility in April of 2025 and was not responsible for completing the MDS assessment. MDS Coordinator #1 stated the facility was restraint free, and that no residents currently residing in the facility used bed rails. He stated the MDS was coded inaccurately. MDS Coordinator #1 further stated he would modify the assessment and resubmit.

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F 641	Continued From page 19 An interview on 05/22/25 at 12:25 PM with the Director of Nursing revealed she expected MDS assessments to be coded correctly to reflect the individual resident. An interview on 05/22/25 at 1:54 PM with the Administrator revealed he expected all MDS assessments to be coded correctly to reflect the residents' conditions.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		6/18/25

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F 656	Continued From page 20 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan in the area of colostomy care for 1 of 1 resident reviewed for colostomy care (Resident #35). The findings included: Resident #35 was admitted to the facility 4/13/22 with diagnoses that included colostomy status. The annual Minimum Data Set (MDS) assessment dated 1/22/25 indicated Resident #35 was coded for having a colostomy. Resident #35's comprehensive care plan dated 2/18/25 revealed no problem areas or interventions related to colostomy care.	F 656	Resident #35s Care Plan was updated on 5/22/2025 to reflect Colostomy status. The Minimum Data Set (MDS) Coordinator completed a 100% Care Plan audit of all residents with a Colostomy to ensure a Comprehensive Care Plan has been completed. No other concerns were identified. This audit was completed on 6/11/2025 The Regional Director of Clinical Reimbursement re-educated the Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) assistant on completing a Comprehensive	

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F 656	Continued From page 21 During an interview with MDS Coordinator #2 on 5/21/25 at 4:00 PM she stated there were no interventions related to colostomy care in Resident #35's care plan which was an oversight on her part. An interview conducted with the Director of Nursing (DON) on 5/22/25 at 3:59 PM revealed Resident #35's colostomy status was a significant part of her care and should have been included in the comprehensive care plan. An interview with the Administrator on 5/22/25 at 4:24 PM indicated that goals and interventions related to colostomy care should be included in the resident's comprehensive care plan.	F 656	Care Plan for residents with a Colostomy. Re-education was completed on 5/22/2025. This education will be added to the facility orientation program for newly hired Minimum Data Set (MDS) employees. The Minimum Data Set (MDS) Coordinator/designee will audit 5 care plans weekly for 12 weeks to ensure residents with a colostomy have a comprehensive care plan in place. The Minimum Data Set (MDS) Coordinator/designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		6/18/25

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F 688	Continued From page 22 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews, the facility failed to apply a right-hand splint for 1 of 3 sampled residents reviewed for limited range of motion (Resident #73). Findings included: Resident #73 was admitted to the facility on 08/16/22 with diagnoses that included cerebrovascular accident (CVA). An active physician order originally dated 11/16/23 revealed a right resting hand splint, on after AM care and off after PM care daily. A review of Resident #73's medical record revealed an Occupational Therapy (OT) discharge summary dated 12/20/2024 indicated Resident #73 had a diagnosis of hemiplegia (a condition that causes paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis) following a cerebral infarction affecting the right dominant side. A splint program was established. Resident #73 had been agreeable to donning splint and self-doffs the splint 1-2 hours later. The summary stated Resident #73 should be wearing the right resting hand splint for up to 8 hours/day. OT completed staff/caregiver education for splinting	F 688	Resident #73 was re-evaluated by Occupational Therapist on 5/21/2025 without decline in right hand mobility, no skin breakdown or new injuries to right hand. Right hand splint was re-ordered for Resident #73. The Therapy Director/Designee audited all residents with splints to ensure splints were available and being applied per order. This audit was completed on 5/23/2025. No other areas of concern were Identified. The Director of Nursing/Designee re-educated all nursing staff on ensuring splints are available, notification to therapy if splints are not in resident's rooms and applying splints per order. Re-education was completed on 6/17/2025. This education will be added to the facility orientation program for all new nursing employees. The Therapy Director/Designee will audit 5 residents with splints weekly for 12 weeks to ensure splints are available and applied per order.	

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F 688	Continued From page 23 program with appropriate staff/caregivers and would then transition into the splinting program due to no further need for OT to address. Resident #73's quarterly Minimum Data Set Assessment (MDS) dated 03/16/25 coded the resident as unable to complete the cognition portion of the assessment. He was coded as needing limited assistance of one staff member for toileting and transfers. His functional limitation in range of motion indicated he had no impairment to his upper extremity and lower extremity. A review of the May 2025 Medication Administration Record revealed documentation of Resident #73's right hand splint being on every AM from 5/1/25 through 5/21/25. Further review revealed the right-hand splint was documented as being on every AM shift on 05/19, 05/20 and 05/21 by Nurse #1. Resident #73 was observed on 05/19/25 at 11:13 AM without a splint to the right hand and the right hand was noted to be flaccid (limp and lacking voluntary movement). During the observation and interview, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. Resident #73 was observed to be pointing to his right hand to alert the surveyor that there was an issue. Resident #73 was unable to communicate verbally with the surveyor however was able to answer by giving a thumbs up for yes and a thumbs down for no. When asked the question, do the staff apply the hand splint, Resident #73 gave a thumbs down for no. The surveyor then asked if Resident #73 could apply the hand splint himself and he gave a thumbs down for no. The right-hand splint was not observed to be in	F 688	The Therapy Director/Designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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	345489	A. BUILDING _____ B. WING _____	C 05/23/2025

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F 688	Continued From page 24	F 688		

Resident #73's room.

Resident #73 was observed on 05/21/25 at 10:42 AM lying in bed. During the observation, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed.

Resident #73 was observed on 05/21/25 at 2:25 PM sitting in his wheelchair in the resident common area. The right-hand splint was not observed on Resident #73's hand.

An interview conducted on 05/21/25 at 2:25 PM with Nurse Aide #1 revealed she hadn't seen Resident #73s right hand splint for several weeks. NA #1 stated she hadn't seen it placed on his right hand for over a month. She stated she thought therapy staff applied the residents splint and not nursing staff. The interview revealed she had not received education on applying the splint to Resident #73's right hand nor was told to.

An interview conducted on 05/21/25 at 2:35 PM with Nurse #1 revealed she thought Resident #73 had a right-hand splint but that he removed it himself. She stated she would sometimes observe it when she went into the room to administer his medication, and that Therapy staff were good about applying it in the mornings after AM care. She stated in particular on 05/21/25 that she did not apply Resident #73's right hand splint because she thought therapy services were applying it.

An interview conducted on 05/21/25 at 10:50 AM with the Therapy Director revealed Resident #73 was discharged from therapy services on 03/22/25. She stated the last time Resident #73 was evaluated for his right-hand splint was

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F 688	Continued From page 25 12/20/24 in which they recommended the right-hand splint with a goal of 6-8 hours wearing the splint. She stated Resident #73 could remove the splint himself after it was applied. She stated the nursing staff were responsible for putting the right-hand splint on the resident and would have been provided education in December based on the Physical Therapy discharge summary. The Therapy Director indicated she had just evaluated Resident #73 prior to the interview and Resident #73's right hand mobility had not gotten worse since the last evaluation on 12/20/24 and he had not developed any skin breakdown or new injury to the right-hand. An interview was conducted on 05/22/25 at 12:25 PM with the Director of Nursing (DON). The DON stated Resident #73's splint should have been applied as indicated in the physician's orders. The DON stated it was her expectation for nursing assistants to apply the splint and if they had any difficulties then they should have informed their supervising nurse. An interview conducted on 05/22/25 at 1:54 PM with the Administrator revealed the nursing staff should have applied the splint as indicated.	F 688		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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	F 842		6/18/25

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F 842	Continued From page 26 except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(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(h)(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; (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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 27 (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(h)(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: Based on record review and staff interviews, the facility failed to ensure a medical record was accurate regarding the Medication Administration Record (MAR). This was for 1 of 1 resident in the area of right-hand splint application (Resident #73) and 1 of 1 resident in the area of medication administration (Resident #69) who were reviewed for medical record accuracy. Findings included: A review of the May 2025 Medication Administration Record revealed documentation of Resident #73's right hand splint being on every AM from 5/1/25 through 5/21/25. Further review revealed the right-hand splint was documented as being on every AM shift on 05/19, 05/20 and 05/21 by Nurse #1.	F 842	Nurse #1 was immediately re-educated by the Director of Nursing on ensuring documentation on the Medication Administration Record is accurate. This re-education was completed on 5/21/2025. Nurse #3 is no longer employed at the facility. The Director of Nursing/Designee audited Medication Administration Records for all residents with splint orders to ensure splints were available and documentation was accurate. No other concerns were noted. This audit was completed on 5/23/2025. The Director of Nursing/Designee reviewed Medication Administration Records for the last 30 days	

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F 842	Continued From page 28 Resident #73 was observed on 05/19/25 at 11:13 AM without a splint to the right hand and the right hand was noted to be flaccid (limp and lacking voluntary movement). During the observation and interview, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. Resident #73 was observed to be pointing to his right hand to alert the surveyor that there was an issue. Resident #73 was unable to communicate verbally with the surveyor, however, was able to answer by giving a thumbs up for yes and a thumbs down for no. When asked the question, do the staff apply the hand splint, Resident #73 gave a thumbs down for no. The surveyor then asked if Resident #73 could apply the hand splint himself and he gave a thumbs down for no. The right-hand splint was not observed to be in Resident #73's room. Resident #73 was observed on 05/21/25 at 10:42 AM lying in bed. During the observation, Resident #73 was observed to be lifting up his right arm and dropping it onto his bed. The right-hand splint was not observed on Resident #73's hand. Resident #73 was observed on 05/21/25 at 2:25 PM sitting in his wheelchair in the resident common area. The right-hand splint was not observed on Resident #73's hand. An interview conducted on 05/21/25 at 2:25 PM with Nurse Aide #1 revealed she worked with Resident #73 on a regular basis. She stated she hadn't seen Resident #73s right hand splint for several weeks. NA #1 stated she hadn't seen it placed on his right hand for over a month. An interview conducted on 05/21/25 at 2:35 PM	F 842	for all current residents with no bowel movement for 3 days to ensure bowel regimen medications have been properly documented. Any areas of concern were addressed. This audit was completed on 6/17/2025. The Director of Nursing/Designee re-educated all licensed nurses, including Medication Aides on proper documentation on individual residents Medication Administration Records. Re-education was completed on 6/17/2025. This will be added to the facilitys orientation program for all newly hired Licensed Nurses and Medication Aides. The Director of Nursing/Designee will audit 5 Medication Administration Records weekly for 12 weeks for residents with splints to ensure accurate documentation. The Director of Nursing/Designee will audit all residents without a bowel movement for 3 days, weekly for 12 weeks, to ensure bowel regimen medications are properly documented. The Director of Nursing/designee will be responsible for reporting the results of these audits to the facilitys monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based	

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F 842	Continued From page 29	F 842		

with Nurse #1 revealed she thought Resident #73 had a right-hand splint but that he removed it himself. She stated she would sometimes observe it when she went into the room to administer his medication, and that Therapy staff were good about applying it in the mornings after AM care. She stated in particular on 05/21/25 that she did not apply Resident #73's right hand splint because she thought therapy services were applying it. She stated that was why she documented the right hand splint was on.

An interview was conducted on 05/22/25 at 12:25 PM with the Director of Nursing (DON). The DON stated Resident #73's splint should have been applied as indicated in the physician's orders. The DON stated it was her expectation for nursing staff to be accurately document on the MAR.

An interview conducted on 05/22/25 at 1:54 PM with the Administrator revealed the nursing staff should have accurately documented in the medical record.

2. Resident #69 was admitted to the facility on 5/14/24.

The quarterly Minimum Data Set (MDS) assessment dated 3/10/25 indicated Resident #69 was cognitively intact.

A review of current physician order for Resident #69 dated 6/28/2024 revealed to administer Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP. Give 17 grams orally as needed for constipation, mixed with 4 to 8 ounces liquid of choice. Daily as needed.

Record review revealed progress note dated

upon the findings of the audits.

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5/2/2025 entered by Nurse #3. According to the note, Resident #69 had not had a bowel movement in 3 days and was given constipation medication on 5/2/25.

A review of Resident #69's Medication Administration Record (MAR) for May 2025 revealed Nurse #3 did not document the administration of Polyethylene Glycol 3350 oral power in the month of May 2025.

The phone interview on 05/22/25 at 3:43 PM with Nurse #3 revealed she was assigned to review bowel records and report negative findings to providers. Nurse #3 stated she did not remember progress note dated 5/2/25 for Resident #69. Nurse #3 reported that she remembered that Resident #69 had gone 3 days without bowel movement according to bowel records and gave Resident #69 "whatever the provider ordered for constipation." Nurse #3 stated that she would document bowel interventions in the bowel record that was then linked to progress notes. Nurse #3 stated she would have documented any medication given to Resident #3 on his MAR. Nurse #3 stated she had forgotten to chart the medication for the bowel intervention.

The Director of Nursing (DON) was interviewed on 05/22/25 at 04:06 PM. The DON reported Nurse #3 was assigned to review bowel records and work with the providers for bowel interventions for the residents. The DON stated that Nurse #3 should document bowel medications given to the residents in their MAR.

The Administrator was interviewed on 05/22/25 at 01:55 PM. The Administrator reported the nurses were expected to document any medication

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F 842	Continued From page 31 provided to the residents in the residents' MAR. The Administrated stated, "If it was not documented it was not done."	F 842		
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 §483.71 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	F 880		6/18/25

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F 880	Continued From page 32 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, and staff interviews, the facility failed to follow their Hand Hygiene policy when the Unit Manager did not perform hand hygiene before each donning of clean gloves while providing wound care to Resident #7. This deficient practice occurred for 1	F 880	The Unit Manager was immediately re-educated on the facility hand hygiene policy while providing wound care. This re-education was completed on 5/22/2025 by the Director of Nursing. Resident #7	

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F 880	Continued From page 33 of 4 staff members observed for infection control practices (Unit Manager). The findings included: Review of the facility's policy and procedure entitled Hand Hygiene read in part: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: a. Immediately before touching a resident. b. Before performing an aseptic task c. After contact with blood, body fluids, or contaminated surfaces. d. After touching a resident e. After touching the resident's environment f. Before moving from working on a soiled body site to a clean body site on the same resident; and g. Immediately after glove removal. A wound care observation was made on 05/22/25 at 9:13 AM on Resident #7 with the Unit Manager. The Unit Manager was observed cleaning the bedside table with disinfectant wipe and placed her wound supplies on the table after it dried. Unit Manager #1 donned a clean gown and clean gloves. She then removed the old dressing from the resident's sacrum and placed the soiled dressing onto the clean bedside table. She then proceeded to clean the area around the wound with a wound care solution and dry the area with gauze. The Unit Manager doffed her gloves and without sanitizing her hands, donned clean gloves and applied a collagen sheet with a dry dressing to Resident #7's wound. Using the same gloves the Unit Manager was observed assisting Resident #7's brief back on and lower the	F 880	did not have any adverse effects from this deficient practice. All residents receiving wound care have the potential to be affected. The Director of Nursing/Designee reviewed all residents receiving wound care to ensure residents did not have any adverse effects. There were no concerns were noted. This audit was completed on 5/27/2025. The Director of Nursing/Designee re-educated all Licensed Nursing staff on the facility hand hygiene policy. This re-education included performing hand hygiene before applying of clean gloves and removal of gloves while providing wound care. Re-education was completed on 6/17/2025. This education will be added to the facility orientation program for all newly hired Licensed Nursing Staff. The Director of Nursing/Designee will audit 3 dressing changes weekly for 12 weeks to ensure hand hygiene is performed per facility hand hygiene policy, including hand hygiene before each applying clean gloves and removal of gloves. The Director of Nursing/designee will be responsible for reporting the results of these audits to the facility’s monthly QAPI committee meeting for 3 months. The QAPI	

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residents bed to a downward position. She then doffed her gown, washed her hands with soap and water, collected her supplies, wiped down the table and left the resident's room.

An interview conducted on 05/22/25 at 2:10 PM with the Unit Manager revealed she was aware that she had not sanitized her hands each time she had doffed her gloves. She stated she typically did not complete the dressing changes in the facility. However, the Wound Nurse had quit a couple of days before, so she was asked to perform wound care for the day. The Unit Manager stated she immediately realized she had not performed hand hygiene after the observation was made and knew she should have sanitized her hands in between or went into the resident's bathroom to wash her hands with soap and water. The Unit Manager also stated she should have placed the soiled dressing into the trash can instead of placing it onto the clean bedside table with the wound care supplies.

An interview conducted on 05/22/25 at 10:57 AM with the Infection Preventionist (IP) revealed she was not aware of the errors made by the Unit Manager during wound care. She stated her expectation was that she would sanitize her hands every time that she removed her gloves and before putting on clean gloves during wound care. The IP further stated staff received education on infection control annually and multiple times during the year.

An interview on 05/22/25 at 12:25 PM with the Director of Nursing (DON) revealed she was aware of the Unit Manager's errors during wound care and said she had been provided with additional education regarding doffing and

committee will make recommendations and changes as indicated based upon the findings of the audits.

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ROCKWELL PARK REHABILITATION AND HEALTHCARE CENTER	1930 WEST SUGAR CREEK ROAD 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
F 880	Continued From page 35 donning and sanitizing in between glove changes. The DON stated it was her expectation that the Unit Manager followed infection control best practices to avoid introducing microorganisms into the wounds. She further stated the facility typically had a Wound Care Nurse however, she had left that same week, and the Unit Manager was asked to perform the dressing change for the day. An interview on 05/22/25 at 1:54 PM with the Administrator revealed he would expect the Unit Manager to follow the Hand Hygiene policy for wound care.	F 880		