

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Westwood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Ashland Street Archdale, NC 27263	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on record review, observation, and staff interviews, the facility failed to honor a resident's request for his hair to be trimmed to his preferred length by not coordinating a hair cut despite staff's knowledge of the resident's preference. This deficient practice affected 1 of 2 residents reviewed for choices (Resident #48).</p> <p>The findings included:</p> <p>Resident #48 was admitted to the facility on [DATE] with diagnoses which included muscle weakness.</p> <p>Review of Resident #48's admission Minimum Dat Set (MDS) dated [DATE] revealed the resident was cognitively intact.</p> <p>Review of Resident #48's care plan revealed the resident had an activity of daily living (ADL) self-care performance due to weakness and cognitive loss. The goal was for Resident #48 to improve the current level of function in (ADL) through the next 90 days. Interventions included Resident #48 would be able to provide personal hygiene and oral care with supervision.</p> <p>An observation and interview conducted with Resident #48 on 11/17/24 at 12:10 PM revealed the resident's hair was long around his ears and down his neck. Resident #48 further revealed he was frustrated because he had not had his hair trimmed since admission and disliked his hair being long. Resident #48 indicated he had reported to multiple staff but could not recall their names that he needed a haircut but staff reported there was not a beautician at the facility.</p> <p>Interview conducted with Nurse #1 on 11/20/24 at 9:42 AM revealed there had not been a beautician to cut hair for several months. Nurse #1 further revealed nursing staff were unable to cut or trim hair due to not being trained or licensed. Nurse #1 stated she had heard several residents complain that they would like their hair to be cut or fixed. Nurse #1 indicated Resident #48 was a clean and well-kept resident and preferred his hair shorter.</p> <p>Interview conducted with Nurse Aide (NA) #1 on 11/20/24 at 9:58 PM revealed she consistently cared for and assisted Resident #48 with hygiene care. NA #1 further revealed she had never been educated to trim or cut hair. NA #1 stated she had heard other residents complain about there not being a facility beautician. NA #1 indicated she had not observed anyone working in the beauty shop in several months.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview conducted with the Director of Nursing (DON) on 11/20/24 at 11:05 AM revealed she was aware residents had complained of not receiving haircuts. The DON further revealed facility staff were not allowed to cut hair, and it would have to be done by a trained and licensed beautician. The DON indicated she was not aware Resident #48 preferred a haircut but expected residents to receive what they prefer.</p> <p>Interview conducted with the Administrator on 11/20/24 at 2:15 PM revealed he did not recall Resident #48 or other residents complain of not having their hair cut. It was further revealed he was aware the facility did not have anyone to cut hair for several months. The Administrator indicated he was working on getting someone hired, but expected for residents to get a hair cut if they would like.</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725</p> <p>Based on record review, and staff interviews, the facility failed to provide the resident and/or the Responsible Party with a written notification of the reason for a hospital transfer for 2 of 2 residents reviewed for hospitalization (Residents #37 & #30).</p> <p>The findings included:</p> <p>1. Resident #37 was admitted to the facility on [DATE].</p> <p>The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively impaired.</p> <p>The discharge MDS assessment dated [DATE] revealed Resident #37 was discharged to the hospital on 11/11/24 and was readmitted on [DATE].</p> <p>Review of the nursing progress notes revealed there was no documentation that Resident #37 received written notice of discharge or transfer when she was sent to the hospital.</p> <p>An interview was conducted with the Social Worker on 11/19/24 at 11:48 am and she indicated that she did not send a transfer/discharge notice to the resident and/or the responsible party (RP) when Resident #37 was sent to the hospital on 11/11/24. She further revealed she was not sure what the process was for issuing the notices.</p> <p>An interview was conducted with the Unit Manager on 11/19/24 at 1:03pm and she indicated that she was the nurse assigned to Resident #37 at the time she was sent out to the hospital on 11/11/24. She further revealed she sent the discharge paperwork with Resident #37 to the hospital, but the paperwork did not include the notice of transfer/discharge to the hospital.</p> <p>Multiple attempts were made to interview Resident #37's Responsible Party (RP), but attempts were not successful.</p> <p>The Administrator was interviewed on 11/19/24 at 2:18 PM and stated he was aware of the requirements to send written notification to the resident and/or RP when a resident was transferred to the hospital. The Administrator indicated it was the Social Services Director responsibility to provide this information and was unaware this had not been completed.</p> <p>40197</p> <p>2. Resident #30 was admitted to the facility on [DATE].</p> <p>A medical record review revealed Resident #30 was transferred to the hospital on 4/22/24 and readmitted to the facility on [DATE]. She was transferred again to the hospital on 6/3/24 and readmitted to the facility on [DATE]. The medical record review indicated there was no evidence the facility had notified the Responsible Party (RP) in writing for the reason for the transfer to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>An interview occurred with the Social Services Director on 11/19/24 at 11:47 AM who stated she had not sent a written reason for the hospital transfer to the resident and/or RP. She indicated she was not aware of this requirement.</p> <p>Nurse #1 was interviewed on 11/19/24 and stated when a resident was transferred to the hospital a face sheet, Do Not Resuscitate information, the Medication Administration Record and any other information related to the hospital transfer were sent with the resident. She was unsure who sent the hospital transfer notice to the resident and/or RP.</p> <p>During an interview with the Director of Nursing (DON) on 11/19/24 at 1:57 PM, she indicated the Social Services Director was responsible for sending a written reason for the hospital transfer to the resident and/or RP.</p> <p>Multiple attempts were made to interview Resident #30's RP, which were unsuccessful.</p> <p>The Administrator was interviewed on 11/19/24 at 2:18 PM and stated he was aware of the requirements to send written notification to the resident and/or RP when a resident was transferred to the hospital. The Administrator indicated it was the Social Services Director responsibility to provide this information and was unaware this had not been completed.</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725</p> <p>Based on record reviews and staff interviews, the facility failed to provide the resident and their Responsible Party (RP) a written notification of the bed hold policy upon a resident's transfer to the hospital for 2 of 2 residents (Resident #37 and & 30) reviewed for hospitalization . This practice had the potential to impact 54 of 54 residents at the facility.</p> <p>Findings included:</p> <p>1. Resident #37 was admitted to the facility on [DATE].</p> <p>The significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #37 was cognitively impaired.</p> <p>The discharge assessment dated [DATE] revealed Resident #37 was discharged to the hospital on 11/11/24 and was readmitted on [DATE].</p> <p>Review of the nursing progress notes revealed there was no documentation that Resident #37 received written notice of the bed hold policy when she was sent to the hospital.</p> <p>An interview was conducted with the social worker on 11/19/24 at 11:48 am and she indicated that she did not send the bed hold policy to the resident, resident representative when Resident #37 was sent to the hospital on 11/11/24.</p> <p>An interview was conducted with the unit manager on 11/19/24 at 1:03pm and she indicated that she was the nurse assigned to Resident #37 at the time she was sent out to the hospital on 11/11/24. She further revealed she sent the discharge paperwork with Resident #37 to the hospital, but the paperwork did not include the notice the bed hold policy information.</p> <p>Multiple attempts were made to interview the resident representative, but attempts were not successful.</p> <p>The Administrator was interviewed on 11/19/24 at 2:18 PM, and stated he was unaware the bed hold policy was not being sent to the resident and/or RP when a hospital transfer occurred. He explained that there was no process for advising a resident and/or their RP of the bed hold policy and one would be put in place.</p> <p>40197</p> <p>2. Resident #30 was initially admitted to the facility on [DATE].</p> <p>A review of Resident #30's medical record indicated she was transferred to the hospital on 4/22/24 and readmitted to the facility on [DATE]. Resident #30 was transferred again to the hospital on 6/3/24 and readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #30 was cognitively intact.</p> <p>An interview occurred with the Social Services Director on 11/19/24 at 11:47 AM, who stated she was unaware of a bed hold policy having to be sent to the resident and/or Responsible Party (RP) when a resident was hospitalized .</p> <p>On 11/19/24 at 12:00 PM, an interview was completed with Nurse #1. She stated she was unaware of a bed hold policy being sent when a resident was transferred to the hospital by the nursing department.</p> <p>The Administrator was interviewed on 11/19/24 at 2:18 PM, and stated he was unaware the bed hold policy was not being sent to the resident and/or RP when a hospital transfer occurred. He explained that there was no process for advising a resident and/or their RP of the bed hold policy and one would be put in place.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197</p> <p>Based on record reviews, observations and interviews with residents and staff, the facility failed to provide routine hair trimming as part of basic hygiene services for residents whose payor source was Medicaid. This was for 2 of 6 residents reviewed for Activities of Daily Living (ADL) (Residents #16 and #26).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #16 was admitted to the facility on [DATE]. <p>An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #16 was cognitively intact.</p> <p>During an interview and observation with Resident #16 on 11/17/24 at 11:45 AM, he expressed that he would like to have his hair cut as it was longer than he liked to wear it. He explained he had his hair cut about six to eight weeks ago by someone he paid to come cut his hair and that he had asked staff several times about getting his hair cut. Resident #16 was unable to recall the staff that he talked to about getting his hair cut. Resident #16's hair touched his collar in the back and was long around the ears.</p> <p>On 11/19/24 at 3:00 PM, the Social Services Director was interviewed and stated that she had begun employment at the facility towards the end of August 2024 and has not received any concerns about Resident #16 wanting his hair cut. She added she was unsure whose role it was to cut resident's hair.</p> <p>Nurse #1 was interviewed on 11/20/24 at 9:42 AM and stated that nursing staff did not trim resident's hair and didn't know how residents got their haircut.</p> <p>An interview occurred with Nurse Aide #1 on 11/20/24 at 9:58 AM who was familiar with Resident #16. She stated Resident #16 had complained about needing his hair cut but she was unsure who to report it to. She added Nurse Aides did not cut residents hair.</p> <p>The Unit Manager was interviewed on 11/20/24 at 10:42 AM and stated she had heard Resident #16 was requesting a haircut, but there wasn't any staff in the building to cut his hair. She was unable to state how residents got their hair cut.</p> <p>The Director of Nursing was interviewed on 11/20/24 at 3:00 PM and stated that she had begun employment at the facility April 2024. She stated currently there was no staff in the facility able to cut hair, but residents could have a beautician/barber come in or their family to cut their hair. She was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid.</p> <p>An interview was completed with the Administrator on 11/21/24 at 8:15 AM and explained that he was unaware of Resident #16 requesting a haircut but expected residents to be able to get their hair cut as desired. He was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #26 was admitted to the facility on [DATE].</p> <p>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #26 was cognitively intact.</p> <p>During an interview and observation with Resident #26 on 11/17/24 at 11:30 AM, he expressed that he would like to have his hair cut as it was longer than he liked to wear it and stated he couldn't recall the last time it was trimmed. He explained he had asked staff several times about getting his hair cut but was unable to recall which staff. Resident #26's hair touched his collar in the back and was long around the ears.</p> <p>On 11/19/24 at 3:00 PM, the Social Services Director was interviewed and stated that she had begun employment at the facility towards the end of August 2024 and has not received any concerns about Resident #26 wanting his hair cut. She added she was unsure whose role it was to cut resident's hair.</p> <p>Nurse #1 was interviewed on 11/20/24 at 9:42 AM and stated that nursing staff did not trim resident's hair and didn't know how residents got their haircut</p> <p>An interview occurred with Nurse Aide #1 on 11/20/24 at 9:58 AM who was familiar with Resident #26. She stated Resident #26 has complained about needing his hair cut but was unsure who to report it to. She added Nurse Aides did not cut residents hair.</p> <p>The Unit Manager was interviewed on 11/20/24 at 10:42 AM and stated she had heard Resident #16 was requesting a haircut, but there wasn't any staff in the building to cut his hair. She was unable to state how residents got their hair cut.</p> <p>The Director of Nursing was interviewed on 11/20/24 at 3:00 PM and stated that she had begun employment at the facility April 2024. She stated currently there was no staff in the facility able to cut hair but residents could have a beautician/barber come in or their family to cut their hair. She was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid.</p> <p>An interview was completed with the Administrator on 11/21/24 at 8:15 AM and explained that he was unaware of Resident #26 requesting a haircut but expected residents to be able to get their hair cut as desired. He was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095</p> <p>Based on record review, observations, resident and staff interviews the facility failed to implement interventions to prevent further falls for Resident #6. This was for 1 of 3 residents reviewed for accidents (Resident #6).</p> <p>Findings included:</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnosis that included unsteadiness on feet, orthostatic hypotension, osteoporosis, and dementia.</p> <p>Resident #6's care plan, last revised 08/20/24, indicated she was risk for falls related to cognitive loss, history of falls, weakness, incontinence, and use of psychotropic medication. Resident #6 also had poor safety awareness and required frequent cueing of safety. She had an unsteady gait and continued to transfer/ambulate without assistance due to cognitive loss. The interventions included the following:</p> <p>Undated intervention: Ensure that the Resident #6 was wearing appropriate footwear/non-skid socks when ambulating or mobilizing in wheel chair</p> <p>Fall on 3/17/24: Assist resident with toileting if will allow.</p> <p>Fall on 3/27/24: Re-orient resident to transfer status.</p> <p>Fall on 5/29/24: Educate family on appropriate footwear.</p> <p>Fall on 07/28/24: Encourage Resident #6 to call out for assistance with ambulation.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #6's cognition was severely impaired. She was independent with bed mobility and required supervision or touching assistance with toilet transfers, and chair to bed transfers. She was also coded as requiring moderate assistance with dressing, personal hygiene, and shower transfers and required maximal assistance with toilet hygiene and shower/baths. She had no range of motion impairments. There was one fall coded during the look-back period.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #6's cognition was severely impaired. She was independent with bed mobility and required supervision or touching assistance with toilet transfers, and chair to bed transfers. She was also coded as requiring moderate assistance with dressing, personal hygiene, and shower transfers and required maximal assistance with toilet hygiene and shower/baths. She had no range of motion impairments. There was one fall coded during the look-back period.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of incident report dated 05/29/24 revealed Resident #6 was observed on the floor on her back with a laceration to the back of the head. Resident #6 stated she was looking out of the window, took a step back, and lost her balance. Predisposing situation factors included improper footwear and ambulating without assistance. Other information noted read that shoes were observed to be too big. Interdisciplinary team note read to educate family on appropriate footwear.</p> <p>Review of incident report dated 07/28/24 revealed Resident #6 was observed sitting on bathroom floor with a goose egg noted to the back of her head, pain to her knuckles. and a skin tear to her right forearm. Resident #6's shoes were noted to be too big. Resident #6 stated she slipped. Interdisciplinary team note read for Resident #6 encouraged to call out for assistance with ambulation.</p> <p>An observation and interview were conducted on 11/19/24 at 1:30 PM with Resident #6. She stated her shoes are about a half size too big. Resident was lying on her bed, fully dressed in slacks, a blouse, and tennis shoes. Her feet were crossed, and the back of her shoe/heel was visible revealing a gap approximately a inch between her heel and the inside of the heel of the shoe. She then stated her shoes do alter her balance at times resulting in her falling.</p> <p>An interview was conducted on 11/19/24 at 1:50 PM with Nursing Assistant #4. She stated Resident #6's shoes are little big on her however she requested to wear them. She then stated that tennis shoes and a pair of house slippers was the only shoes Resident #6 had.</p> <p>An interview was conducted on 11/19/24 at 1:50 PM with the Director of Nursing (DON). She stated she was aware Resident #6's shoes were too big after a fall on 05/29/24. An intervention was added to her focus for falls on 05/29/24 to educate family on appropriate footwear. She also stated she was under the impression the family had been notified to bring shoes that fit properly. She indicated she had not gone and looked at Resident #6's shoes. She explained that the intervention that was put in place after the 05/29/24 should have included preventions that the facility could do to prevent further falls due to her shoes being too big. She explained that she expected staff not to use the tennis shoes if they were too big and to use non-skid socks. The DON was aware Resident #6 had fallen again on 07/28/24 due to her shoes being too big and that she should not have fallen twice for the same reason. The DON further stated she was unaware she had not received shoes that fit better and had not followed up on the shoes. She then explained that falls were discussed every morning in the morning meeting and interventions are added to the care plans at that time.</p> <p>An interview was conducted on 11/21/24 at 9:36 AM with the Administrator. He stated he was not aware Resident #6's shoes were too big and possibly causing her falls. He also stated he expected the staff to make sure her shoes fit properly or to apply non-skid socks. He indicated the care plan interventions should reflect and coincide with the reason for the fall and that a root cause investigation should be completed post falls.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415</p> <p>Based on observations, record reviews, Nurse Practitioner, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of 3 residents (Resident #5 and Resident #16) during the medication administration observation.</p> <p>The findings included:</p> <p>a. Resident #16 was admitted to the facility on [DATE] with a diagnosis of retention of urine.</p> <p>A review of Resident #16's active Physician's orders included a current order for Macrobid (antibiotic) capsules 100 milligrams initiated on 11/4/24, one capsule one time daily for long term urinary tract infection prophylaxis.</p> <p>On 11/19/24 at 8:25 AM, the Unit Manager, who was working as a floor nurse, was observed as she prepared 11 of 12 medications for Resident #16. It was noted the Unit Manager had pulled the card containing the ordered Macrobid out of the medication cart, but instead of dispensing the medication in the cup with the others, she laid the medication card down on top of the cart. The nurse then went into the resident's room to administer the other medication. She was asked to step out of the room to the medication cart and then asked to count the medications in the cup. She counted only 11 different medications. She was interviewed about the missing dose, and the Unit Manager stated she should have dispensed the antibiotic with the other medications being administered. She then proceeded to administer the antibiotic as well.</p> <p>b. Resident #5 was admitted to the facility on [DATE] with a diagnosis of dry eye.</p> <p>A review of Resident #5's active physician's orders included a current order for the month of November for Artificial Tears one drop in both eyes every morning and at bedtime for dry eye.</p> <p>On 11/19/24 at 9:08 AM, the Unit Manager was observed as she prepared 10 of the 11 medications ordered for Resident #5. It was noted that the Unit Manager took the Artificial Tears out of the medication cart and laid them on top of the cart. Once she had administered the oral medication the Unit Manager then stated she was going to wheel Resident #5 down to the cafeteria as that was the resident's preferred location to visit with others during the day. She left the area without dispensing the eye drops.</p> <p>On 11/19/24 at 9:22 AM the Unit Manager was interviewed and stated she should have given the eye drops but that she forgot she had not given them.</p> <p>On 11/19/24 at 12:10 PM the Nurse Practitioner was interviewed regarding the missed medications. She stated it was her expectation that the nurses follow her orders and give the medications as she had written.</p> <p>The Director of Nursing was interviewed on 11/19/24 at 3:12 PM. She stated it was her expectation that the nurses give all medications as they are ordered.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Westwood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 625 Ashland Street Archdale, NC 27263	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator was interviewed on 11/19/24 at 3:20 PM. He stated he expected the nurses to follow the medication administration policy and administer medications from one hour before the ordered time to one hour after the ordered time.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50415</p> <p>Based on observations, record review, and staff interviews, the facility failed to date opened vials of insulin and insulin pens stored 2 of 2 medication carts (B and C hall cart, and D and E hall cart) the facility failed to keep a medication refrigerated per manufacturer guidelines in 1 of 2 medication carts (B and C hall cart), and also failed to discard expired medications in 1 of 1 medication storage room.</p> <p>The findings included:</p> <p>a. An observation was conducted on 11/19/24 at 11:19 AM of the D and E hall cart with Nurse #1. The observation revealed 5 Lispro insulin pens were opened and undated, 2 of the 5 Lispro insulin pens were not labeled with resident names, 1 Lantus insulin pen was opened and undated, 1 Basaglar insulin pen was opened and undated. Nurse #1 verbalized that all opened medications should have been dated with the date they were opened. The medications were given to Nurse #3 to be discarded. Per the manufacturer's instructions, insulin should be discarded after 28 days of opening,</p> <p>b. An observation was conducted on 11/19/24 at 2:14 PM of the B and C hall cart with the Unit Manager. The observation revealed 1 vial of Lantus insulin was opened and undated, 1 Lantus insulin pen was opened and undated, 1 Insulin Aspart pen was opened and undated, 1 Basaglar pen was opened and undated, 1 Ozempic pen was opened and undated. Per the manufacturer's instructions, insulin should be discarded after 28 days of opening, The observation also revealed 2 vials of tuberculin purified protein derivative (PPD) testing solution opened and undated, and they were stored in the same box. The vials were not refrigerated per the manufacturer's instructions that stated PPD vials should always be kept refrigerated and protected from light when not in immediate use. The Unit Manager stated all medications should have been dated when they are opened and that refrigerated medications should have been stored in the refrigerator. The medications were given to the Unit Manager to be discarded.</p> <p>c. An observation of the medication storage room was conducted on 11/19/24 at 3:00 PM with Nurse #1. 1 bottle of stock medication Allergy Relief tabs was unopened, and the manufacturer's stamped expiration date was 9/24. Nurse #1 stated that expired medications should be discarded. The medications were given to Nurse #1 to discard.</p> <p>Pharmacist #1 was interviewed on 11/19/24 at 4:25 PM. He stated he visits the facility once each month. His last visit was on November 12th. He verbalized he sample audited 10% of the carts during his visit. He stated he gave the few expired or undated medications to be disposed of by the nurse.</p> <p>On 11/19/24 at 3:12 PM the Director of Nursing (DON) was interviewed. She stated she expected the nurses to date all medications when they are opened and store them correctly. She stated that insulin was supposed to be discarded 28 days after opening. She revealed that the unit managers were responsible for auditing the medications carts for expired medications.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Administrator was interviewed on 11/19/24 at 3:20 PM. He stated he expected the nurses to date all medications when they were opened. He stated he expected insulin to be discarded 28 days after being opened.</p>

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197</p> <p>Based on record reviews, and staff interviews, the facility failed to have complete and accurate documentation for wound care (Residents #30, #55 and #56). This was for 3 of 35 resident records reviewed.</p> <p>The findings included:</p> <p>1. Resident #30 was originally admitted to the facility on [DATE] with diagnoses of surgical aftercare for right below the knee amputation, and diabetes type 2.</p> <p>Resident #30 was seen in the hospital 4/22/24 to 5/1/24 for wound healing complication to the right below the knee amputation site. She underwent a revision to an above the knee amputation and returned to the facility for surgical wound care. Resident #30 required another hospitalization from [DATE] to 6/8/24 for altered mental status.</p> <p>Resident #30's physician orders revealed the following:</p> <ul style="list-style-type: none"> - An order dated 6/10/24 to clean the wound to the left forearm with wound cleanser, apply Xeroform gauze (a sterile, medicated, non-adhering protective dressing) and a dry dressing daily. - An order dated 6/10/24 to cleanse the surgical incision to the right leg with normal saline. Apply Xeroform gauze and dry dressing daily. <p>The June 2024 Treatment Administration Record (TAR) was reviewed and revealed the left forearm and right leg wound care had not been documented as completed or refused by Resident #30 for the day shift on 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/15/24, 6/16/24, 6/24/24, and 6/27/24.</p> <p>On 11/20/24 at 1:20 PM, an interview occurred with the Unit Manager. She explained she had been the facility wound care nurse from March 2024 until November 2024. She explained that she was pulled to the floor a lot during the month of June 2024 but always made sure the wound care had been completed. She was scheduled for the 7:00 AM to 7:00 PM shift on 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/24/24 and 6/27/24 and could not recall Resident #30 refusing wound care to her left forearm or right leg. She verified the dates in question and stated she completed the wound care as ordered but had forgotten to sign them as completed.</p> <p>The DON was interviewed on 11/20/24 at 3:00 PM. She was scheduled on the 7:00 AM to 7:00 PM shift to care for Resident #30 on 6/15/24 and 6/16/24. After reviewing the TAR she stated she could not recall Resident #30 refusing wound care and that she completed it as ordered but must have forgotten to sign it off as completed. The DON added she would expect documentation to be complete and accurate.</p> <p>An interview was completed with the Administrator on 11/21/24 at 8:15 AM, who stated he expected wound care documentation to be complete and accurate.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #55 was admitted to the facility on [DATE] with diagnoses that included a right femur fracture, end stage renal disease and congestive heart failure.</p> <p>Resident #55's physician orders included the following:</p> <p>An order dated 5/3/24 to cleanse the open area to the coccyx with wound cleanser, apply calcium alginate (a highly absorbent dressing) and cover with bordered gauze every night shift. This order was changed on 5/8/24 to be completed during the day shift. On 5/15/24 this order was changed to cleanse the pressure wound to the coccyx with wound cleanser, apply calcium alginate with silver and a super absorbent dressing every day.</p> <p>An order dated 5/8/24 to cleanse the pressure wound to the left hip with wound cleanser, apply calcium alginate and cover with bordered gauze every day shift.</p> <p>The May 2024 TAR was reviewed and revealed the left hip and coccyx wound care had not been documented as completed or refused by Resident #55 on 5/3/24, 5/4/24, 5/5/24, 5/10/24, 5/11/24, 5/13/24, 5/14/24, 5/16/24 and 5/19/24.</p> <p>On 11/19/24 at 2:00 PM, a phone interview occurred with Nurse #2 who was scheduled to care for Resident #55 on 5/14/24 and 5/19/24. She stated she made sure wound care was completed but may have forgotten to document it as complete.</p> <p>A phone interview was completed with Nurse #3 on 11/20/24 at 2:04 PM. She was scheduled to care for Resident #55 on the night shift on 5/3/24, 5/4/24, 5/5/24 and 5/13/24. She could not recall Resident #55 refusing wound care and stated she always ensured it was completed but may have forgotten to document that it was completed.</p> <p>A phone interview was completed with Nurse #4 on 11/20/24 at 2:10 PM, who was scheduled to care for Resident #55 on the night shift on 5/11/24. He could not recall Resident #55 refusing wound care but may have gotten busy and forgot to document the wound care as completed.</p> <p>On 11/20/24 at 2:23 PM, a phone interview occurred with Nurse #5 who was scheduled to care for Resident #55 on 5/16/24. She recalled Resident #55 and could not recall her refusing wound care. She stated she forgot to sign the TAR that the wound care had been completed.</p> <p>The DON was interviewed on 11/20/24 at 3:00 PM. She reviewed the May 2024 TAR for Resident #55 and stated she would expect the documentation to be complete and accurate.</p> <p>An interview was completed with the Administrator on 11/21/24 at 8:15 AM, who stated he expected wound care documentation to be complete and accurate.</p> <p>3. Resident #56 was admitted to the facility on [DATE] with diagnoses that included diabetes type 2 and a stage 3 pressure ulcer to the sacral region.</p> <p>A review of the Resident #56's physician orders included an order dated 5/23/24 to cleanse the pressure ulcer to the sacrum with normal saline. Apply calcium alginate with silver and collagen powder to the wound bed and cover with a bordered gauze every day shift.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>The June 2024 TAR was reviewed and revealed the sacral wound care had not been documented as completed or refused by Resident #56 on 6/3/24, 6/4/24, 6/6/24, 6/7/24, 6/8/24, 6/9/24, 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/15/24, 6/16/24, 6/24/24 and 6/25/24.</p> <p>On 11/20/24 at 1:20 PM, an interview occurred with the Unit Manager. She explained she had been the facility wound care nurse from March 2024 until November 2024. She explained that she was pulled to the floor a lot during the month of June 2024 but always made sure the wound care had been completed. She was scheduled for the 7:00 AM to 7:00 PM shift on 6/4/24, 6/6/24, 6/7/24, 6/8/24, 6/9/24, 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/24/24 and 6/25/24 and could not recall Resident #56 refusing wound care to her sacrum. She verified the dates in question and stated she completed the wound care as ordered but had forgotten to sign them as completed.</p> <p>The DON was interviewed on 11/20/24 at 3:00 PM. She reviewed the May 2024 TAR for Resident #56 and stated she would expect the documentation to be complete and accurate.</p> <p>An interview was completed with the Administrator on 11/21/24 at 8:15 AM, who stated he expected wound care documentation to be complete and accurate.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50415</p> <p>Based on observation, record review, and staff interviews, the facility failed to disinfect a glucometer (used to check a resident's blood glucose level) after using per manufacturer's guidelines for 1 of 1 resident (Resident #29). The glucometer was individually assigned to Resident #29 and stored in the medication cart.</p> <p>The findings included:</p> <p>Review of facility policy titled Blood Glucose Monitoring and Disinfecting revised date 4/20/22 read in part; clean and disinfect the meter with disinfecting wipes (per manufacture guidelines), place meter in resident specific bag for storage.</p> <p>Review of the glucometer manufacturer's guidelines stated to disinfect, the meter's surface should be thoroughly wet with a Sani cloth wipe and allowed to remain wet for a full 2 minutes. Let air dry.</p> <p>A continuous observation was made on 11/19/24 from 1:04 PM to 1:10 PM. Nurse #1 opened the medication cart and removed the glucometer labeled for Resident #29. She then entered Resident #29's room prepared to check her blood glucose level. She cleaned Resident #29's finger on her left hand with an alcohol swab and then pricked the finger with a lancet device to obtain a blood sample. Nurse #1 then placed a drop of blood onto the testing strip that had been inserted into the glucometer. Nurse #1 then disposed of the trash. She removed her gloves and exited the room. She proceeded back to the medication cart where she performed hand hygiene. She then opened the bottom drawer of the cart, retrieved the pouch labeled with Resident #29's name and placed the used meter into the pouch and put it back into the medication cart without cleaning it and closed the drawer.</p> <p>Nurse #1 was immediately interviewed regarding the facility's policy for cleaning glucometers after use. She stated that it was the policy to clean the meters both before and after use. Nurse #1 then retrieved the soiled meter out of the cart and wiped it down with an alcohol pad and placed it in a plastic cup to dry. She was questioned about what product was supposed to be used to clean the meters. Nurse #1 stated that she used alcohol swabs to clean the meters, but there was something specific that was supposed to be used, but she didn't know the name of it. There were no disinfecting wipes on the cart.</p> <p>An interview was conducted with the Director of Nursing on 11/19/24 at 3:12 PM. She stated that nurses were supposed to clean/disinfect the glucometers after testing blood sugars of all residents using Sani wipes and that it is unacceptable to use alcohol swabs.</p> <p>The Administrator was interviewed on 11/19/24 at 3:20 PM. He stated that he expected the facility policy to be followed for cleaning/disinfecting glucose testing meters.</p>		