STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stewart Health Center	6920 Marching Duck Drive Charlotte, NC 28210

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review and staff interviews the facility failed to ensure that the resident's Medical Order for Scope of Treatment (MOST) form was signed by the resident or resident representative for 1 of 2 residents reviewed for Advanced Directives (Resident #38). The findings included: Resident # 38 was admitted to the facility on [DATE]. A review of Resident #38's paper medical record located at the nursing station revealed a MOST form dated 6/8/2023. The MOST form indicated Resident #38 was a DNR and was signed by the Nurse Practitioner (NP). The MOST form did not have the required resident or resident representative signature on the front page of the document. A review of the active physician's order dated 11/30/2023 revealed Resident #38 was a DNR. Resident #38's care plan dated 1/11/2024 revealed goals and interventions for DNR (Do Not Resuscitate) to be implemented. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #38 was severely cognitively impaired. An interview was conducted on 3/6/2024 at 9:55 am with Nurse #1. Nurse #1 reported that DNR and MOST forms were kept in a book at the nurse's station. He verbalized that the Medical Doctor (MD) or Nurse Practitioner (NP) and the resident or resident representative were required to sign the MOST form after it was completed. Nurse #1 reported that if the resident was unable to sign and the resident representative was not physically in the facility during the discussion of code status that a member of management would obtain the representative's signature the next time that they came to visit the resident. Nurse #1 was unaware that there was no resident or resident representative signature on Resident #38's MOST form and indicated that it should have been on the front of the MOST form. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 3/6/2024 at 10:49 am with the Director of Nursing (DON). The DON reported that on admission, the Social Worker (SW) was responsible for identifying if the resident had an advanced directive in place. The SW would then get a copy of the advanced directive. She stated if a resident did not have an advanced directive, the SW would notify the MD to have them discuss advanced directives with the resident and/or resident representative. The DON reported that education about advanced directives was provided by the MD or NP and should be dictated within their note on admission. The DON was unaware that there was not a resident or resident representative signature on Resident #38's MOST form and verbalized that there should be a signature by the resident or resident representative. An interview was conducted on 3/7/2024 at 9:48 am with the SW. The SW reported that prior to admission, if a resident has an advanced directive, she would ask the resident or their representative to provide a copy of the document. She reported that the MD or NP would review the code status and advanced directives with the resident and/or resident representative on admission, provide education about code status, and complete the MOST form or DNR at that time. The SW verbalized that consent could be obtained over the phone and that the family would sign the document when they came into the facility, or telephone consent should be indicated on the MOST form, itself. The SW indicated that if the resident was unable to sign and their representative was not available, a golden DNR form was usually completed. An interview was conducted on 3/7/2024 at 2:20 pm with the Administrator. The Administrator stated prior to a resident being admitted to the facility, the SW would obtain copies of any advanced directives that were already in place. If a resident did not have an advanced directive on admission, the SW would reach out to the MD or NP to have them discuss and educate the family about code status. The Administrator verbalized that a lot of conversations regarding code status occurred over the phone. She stated that they would try to get a resident representative to sign the MOST form the next time they came to visit. The Administrator was not aware that Resident #38's MOST form did not have a resident or resident representative signature and verbalized that it should be signed.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 1 of 3 residents (Resident #29) reviewed for beneficiary protection notification. The findings included: Resident #29 was admitted to the facility on [DATE]. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was issued on 01/16/2024 to Resident #29's Responsible Party (RP) which explained Medicare Part A coverage for skilled services would end on 01/18/2024. Resident #29 was residing in the facility during the recertification survey conducted from 03/04/2024 through 03/07/2024. A review of the medical record revealed a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (ABN) was not provided to Resident #29 or their RP. An interview was conducted with the Social Worker and the Administrator on 03/06/24 at 10:05 AM. The Social Worker confirmed Resident #29 remained in the facility after their Medicare Part A benefit ended and a CMS-10123 NOMNC was issued to the RP however a CMS-10055 ABN was not provided. The Social Worker indicated she was unaware of the circumstances in which a CMS-10055 ABN was required to be issued to a resident and/or RP. The Administrator stated when a resident's Medicare Part A benefit was ending and they remained in the facility, a CMS-10123 NOMNC and a CMS-10055 ABN should be issued to the resident and/or RP.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on observations, record review, family and staff interviews the facility failed to maintain privacy during care and failed to obtain written consent for the use of cameras in residents' rooms for 2 of 2 samples residents reviewed for privacy (Resident #13 and #38). A reasonable person would expect privacy when care was being provided and not have a monitor screen showing them with private areas exposed and would feel humiliated and dehumanized. Findings included: 1. Resident #13 was admitted to the facility on [DATE]. The admission MDS dated [DATE] revealed Resident #13 was moderately cognitively impaired and had not exhibited any behaviors. A review of Resident #13's medical record revealed that no written consent for camera usage was obtained. An observation was conducted on 3/4/2024 at 12:34 pm. Resident #13 did not have a roommate and a camera was visualized on top of the cabinet in Resident #13's room. A monitor for the associated camera in Resident #13's room was left unattended on the edge of an un-enclosed office desk. The camera monitor was able to be visualized approximately one foot away and was visible to visitors as they approached the desk. A telephone interview was conducted 3/4/2024 at 2:54 pm with Resident #13's Representative. The RR reported that nursing staff at the family had reached out to her about placing a camera in Resident #13's room because she had been getting up at night and had tried to get out of the facility. She reported that staff were so busy at night that having a camera in the room was an easy way for them to make sure Resident #13 did not get out of bed. The RR stated that she had agreed to placing a camera in the room and did not recall signing a consent form. An interview was conducted on 3/6/2024 at 9:50 am with Nurse #1. Nurse #1 stated Resident #13 had a camera since she had been in her room. He reported that Resident #13 had fallen approximately two to three times prior to the camera being installed. Nurse #1 reported that camera monitors were never left unattended at the nurses station and that the monitors were portable and could be taken with the nurse if they had to leave the nurse's station. An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). The DON stated several residents had cameras in their rooms. She reported that cameras remained on 24 hours per day and were not turned off. She reported that camera monitors should not be left unattended at the nurse's station, however there were times when a staff member would not be present at the nurse's station and camera monitors would be visible to visitors. The DON did report that anyone who approached the desk could potentially observe incontinence care on the camera monitor. The DON was not certain if a consent was obtained for camera usage for Resident #13. (continued on next page)

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F 0583 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 3/6/2024 at 12:39 pm with NA #3. NA #3 reported that Resident #13 had always had a camera in her current room. She reported that Resident #13 had been having issues with balance and had been visualized walking backwards with her walker, which had caused staff to be concerned about falling. NA #3 reported that the camera would be turned off, moved, or covered during incontinence care. An observation was conducted on 3/7/2024 at 7:50 am. Resident #13 did not have a roommate. The camera monitor was able to be visualized approximately one foot away and was visible to visitors as they approached the un-enclosed desk at the nurse's station. Resident #13 was observed sitting on the side of the bed with no brief, no pants, and her private areas were exposed as Nurse Aide Student #1 assisted her getting dressed. An interview was conducted on 3/7/2024 at 10:16 am with NA #3. NA #3 reported Nurse Aide Student #1 had provided care for Resident #38 when she arrived on first shift (7:00 am to 3:00 pm). NA #3 stated she was not aware that Resident #13 had been exposed during care. She verbalized that a nurse was typically at the desk with the monitor and would move the camera angle away from the resident during care. An interview was conducted on 3/7/2024 at 2:06 pm with the Administrator. The Administrator reported that several residents do have cameras in their rooms. She reported that cameras remained on for 24 hours per day, were never turned off, and that camera monitors were always to be attended at the nurse's station or at least out of view of visitors. She reported that facility staff did not obtain consent for camera usage because it was viewed as an extra level of supervision. The Administrator was unaware written consents were required for the usage of cameras. 2. Resident # 38 was admitted to the facility on [DATE]. Resident #38's care plan dated 1/11/2024 revealed goals and interventions for falls which included staff being educated about not leaving camera monitors unattended. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #38 was severely cognitively impaired and had not exhibited any behaviors. A review of Resident #38's medical record revealed that no written consent for camera usage was obtained. An interview was conducted on 3/6/2024 at 10:01 am with Nurse #1. Nurse #1 reported that Resident #38 had a camera in his room since he started working at the facility in November of 2022. He reported that Resident #38 was able to walk at the time the camera was installed. He verbalized that Resident #38 would attempt to walk around in his room without assistance and had attempted to leave the facility to go home. Nurse #1 reported that camera monitors were never left unattended at the nurses station and that the monitors were portable and could be taken with the nurse if they had to leave the nurse's station. He stated that he thought either verbal or written consent was obtained for the usage of cameras but was unable to locate the consent for Resident #38. (continued on next page)

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F 0583 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). The DON stated several residents had cameras in their rooms. She reported that cameras remained on 24 hours per day and were not turned off. She reported that camera monitors should not be left unattended at the nurse's station, however there were times when a staff member would not be present at the nurse's station and camera monitors would be visible to visitors. The DON was not certain if a consent was obtained for camera usage for Resident #38. An interview was conducted on 3/6/2024 at 12:47 pm with Nurse Aide (NA) #3. NA #3 reported that Resident #38 had a camera in his room for as long as she could remember. She reported that in the past Resident #38 would try to leave the building and expressed a desire to leave the facility. NA #3 reported that the camera would be turned off, moved, or covered during incontinence care. An observation was conducted on 3/7/2024 at 7:50 am. Resident #38 had a camera mounted on the wall in his room and did not have a roommate. The camera monitor for Resident #38 was left unattended at the nurse's station. The camera monitor was able to be visualized approximately one foot away and was visible to visitors as they approached the un-enclosed desk at the nurse's station. Resident #38 was observed with his brief on and his pants around his ankles with both legs exposed while lying in bed as he received incontinence care by NA #3. An interview was conducted on 3/7/2024 at 10:16 am with NA #3. NA #3 reported that she performed incontinence care for Resident #38 when she arrived on shift (3/7/2024). NA #3 stated she did not move the camera when she provided incontinence care, because the camera was positioned too high on the wall for her to reach. She verbalized that a nurse was typically at the desk with the monitor and would move the camera angle away from the resident during incontinence care. An interview was conducted on 3/7/2024 at 2:06 pm with the Administrator. The Administrator reported that several residents do have cameras in their rooms. She reported that cameras remained on for 24 hours per day, were never turned off, and that camera monitors were always to be attended at the nurse's station or at least out of view of visitors. She reported that facility staff did not obtain consent for camera usage because it was viewed as an extra level of supervision.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49055 Based on record reviews and staff interviews, the facility failed to complete and transmit a discharge and a death Minimum Data Set (MDS) assessment within the required timeframe for 2 of 3 residents reviewed for resident assessments (Resident #52 and Resident #18). The findings included: 1. Resident #52 was admitted to the facility on [DATE]. A review of Resident #52's medical record revealed that she was discharged to assisted living on [DATE]. A review of Resident #52's medical record revealed the last completed MDS was an admission MDS assessment dated [DATE]. There was no discharge MDS assessment completed or transmitted. During an interview on [DATE] at 3:19 pm with the MDS Coordinator, she checked both the former electronic medical record system and the current electronic medical record system, and was not able to locate a discharge MDS in either system. She stated that she was not sure why a discharge MDS assessment was not completed or transmitted for Resident #52. During an interview on [DATE] at 1:07 pm with the Administrator, she stated that Resident #52's discharge MDS should have been completed or transmitted within 14 days, per the regulatory guidelines. 2. Resident #18 was admitted to the facility on [DATE]. A review of Resident #18's medical record revealed that she expired in the facility, with her family at her bedside, on [DATE]. A review of Resident #18's medical records revealed the last MDS completed was her annual MDS assessment dated [DATE]. There was no death MDS assessment completed or transmitted. During an interview on [DATE] at 3:19 pm with the MDS Coordinator, she checked both the former electronic medical record system and the current electronic medical record system, and was not able to locate a death MDS assessment in either system. She reported that a death MDS assessment was probably not done due to the trainings being completed on the facility's new electronic medical record system. During an interview on [DATE] at 1:07 pm with the Administrator, she stated that Resident #18's death MDS assessment should have been completed and transmitted within 14 days, per the regulatory guidelines.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on observations, record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for functional limitations in range of motion, and anticoagulant medication for 2 of 4 residents reviewed for accuracy of assessments (Residents #38 and #209). Findings included: 1. Resident #38 was admitted to the facility on [DATE] with diagnoses which included muscle weakness. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #38 had severe cognitive impairment, no impairment of the lower extremities, and required partial to moderate assistance from sitting to standing. An observation was conducted on 3/5/2024 at 2:43 pm. Nurse Aide (NA) #1 and NA #2 were observed using a sit-to-stand mechanical lift to transfer Resident #38 from the wheelchair to the toilet and back to his wheelchair during incontinence care. An interview was conducted on 3/5/2024 at 2:47 pm with NA #1. NA #1 reported that Resident #38 required the use of a mechanical lift during transfers due to his inability to walk. An interview was conducted on 3/6/2024 at 2:55 pm with the MDS Coordinator. The MDS Coordinator reported she was aware that Resident #38 required maximal assistance during transfers. She reported she would only code impairment of the lower extremities if an extremity was broken, deformed, or paralyzed. An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). The DON reported the MDS Coordinator was responsible for accurately completing MDS assessments. The DON was not aware that Resident #38's MDS was not coded for impairment of the lower extremities and verbalized that it should have been. An interview was conducted 3/7/2024 at 2:18 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for accurately completing MDS assessments. She stated impairment of the lower extremities should be coded on the MDS. 2. Resident #209 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heart rhythm). A review of Resident #209's medical record revealed an active order dated 2/15/2024 for apixaban (anticoagulant medication used to prevent blood clots) 5 milligrams to be administered twice a day. A review of Resident #209's Medication Administration Record indicated Resident #209 had received apixaban daily starting on 2/15/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) dated [DATE] did not indicate Resident #209 had received anticoagulation medication. An interview was conducted on 3/6/2024 at 11:02 am with the Director of Nursing (DON). The DON reported that the MDS Coordinator was responsible for accurately completing MDS assessments. The DON was not aware that the use of anticoagulants had not been coded on Resident #209's MDS and verbalized that it should have been. An interview was conducted on 3/6/2024 at 3:27 am with the MDS Coordinator. The MDS coordinator reported she was aware that Resident #209 was on apixaban. She stated it was not coded correctly because she thought apixaban was an antiplatelet medication. An interview was conducted on 3/7/2024 at 2:22 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for accurately completing MDS assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on observations, record reviews, and staff interviews the facility failed to develop and implement a person-centered care plan for residents on anticoagulants (Resident # 209 and Resident #20), residents on psychotropic medications (Resident #210, #20, and #259), and a resident with a wander/elopement alarm (Resident #13) for 5 of 5 residents reviewed for development and implementation of a comprehensive care plan. Findings included: 1) Resident #209 was admitted to the facility on [DATE] with diagnoses which included chronic atrial fibrillation (irregular heart rhythm). Resident 209's care plan dated 2/15/2024 did not include goals and interventions for the use of anticoagulants. A record review revealed Resident #209 had active orders dated 2/15/2024 for apixaban (blood thinner) 5 milligrams to be administered twice a day and was to be monitored for signs and symptoms of bleeding. An admission Minimum Data Set (MDS) dated [DATE] indicated Resident #209 was moderately cognitively impaired. A review of Resident #209's Medication Administration Record (MAR) for February 2024 and March 2024 revealed he had taken apixaban 5 milligrams twice daily since 2/5/2024. An interview was conducted on 3/6/2024 at 10:10 am with Nurse #1. Nurse #1 stated that Resident #209 was on apixaban and verbalized the resident should be monitored for signs and symptoms of bleeding. Nurse #1 reported he was unsure if the use of anticoagulants were included in the care plan for Resident #209. An interview was conducted on 3/6/2024 at 10:32 am with the Director of Nursing (DON). She stated that the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. The DON stated any resident on an anticoagulant should be monitored for signs and symptoms of bleeding. She reported the use of anticoagulants should be care planned and include goals and interventions. The DON was not aware Resident #209 did not have a care plan for anticoagulants and verbalized that he should have. An interview was conducted on 3/6/2024 at 2:49 pm with the MDS Coordinator. The MDS coordinator stated she was responsible for creating and updating care plans. She stated if a resident was prescribed anticoagulants, the care plan should include goals and interventions for anticoagulants. The MDS Coordinator verbalized she was not sure why goals and interventions for anticoagulants were not included on Resident #209's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/7/2024 at 2:22 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She stated residents who received anticoagulants should have goals and interventions for anticoagulants on their care plan. The Administrator was not aware that goals and interventions for anticoagulant usage had not been care planned for Resident #209 and reported that it should have been. 2) Resident #210 was admitted to the facility on [DATE] with diagnoses which included generalized anxiety disorder and delirium. Resident #210's care plan dated 1/22/2024 did not include goals and interventions for psychotropic medications. An admission Minimum Data Set MDS dated [DATE] revealed Resident #210 was taking antipsychotic and antianxiety medications, and was cognitively intact. A review of Resident #210's record revealed active orders dated 2/15/2024 for quetiapine fumarate (antipsychotic medication) 12.5 milligrams to be administered daily and every twelve hours as needed. A review of Resident #210's Medication Administration Record (MAR) for February 2024 and March 2024 revealed she had taken quetiapine fumarate 12.5 milligrams daily since 2/16/2024. An interview was conducted on 3/6/2024 at 10:32 am with the Director of Nursing (DON). She verbalized the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. The DON stated when a resident was prescribed a psychotropic medication, they should be monitored for behaviors and included in their care plan. The DON was not aware that Resident #210 did not have a care plan with goals and interventions for psychotropic medications. She verbalized that it should have been care planned. An interview was conducted on 3/6/2024 at 3:20 pm with the MDS Coordinator. The MDS coordinator stated she was responsible for creating and updating care plans. She stated any resident taking psychotropic medications should have goals and interventions for psychotropic medication use in their care plan. The MDS Coordinator did not know why goals and interventions for antipsychotic use were not included in Resident #210's care plan. An interview was conducted on 3/7/2024 at 2:22 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She stated residents who received psychotropic medications should have goals and interventions for psychotropic medication use in their care plan. The Administrator was not aware that goals and interventions for psychotropic medication use had not been care planned for Resident #210 and reported that it should have been. 3) Resident #13 was admitted to the facility on [DATE] with diagnoses which included insomnia. Resident #13's care plan dated 1/5/2024 was not updated to include goals and interventions for a wander/elopement alarm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stewart Health Center	6920 Marching Duck Drive Charlotte, NC 28210

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set MDS dated [DATE] revealed that Resident #13 was moderately cognitively impaired. A record review revealed Resident #13 had active orders dated 2/5/2024 to check the functionality and placement of wander/elopement alarm every shift. An observation was conducted on 3/4/2024 at 12:34 am. Resident #13 was observed sitting in a chair in her room with a wander/elopement alarm on her left ankle. An interview was conducted on 3/6/2024 at 10:40 am with the Director of Nursing (DON). She verbalized the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She was not aware that Resident #13 did not have goals and interventions for a wander/elopement alarm on her care plan and indicated that she should have. An interview was conducted on 3/6/2024 at 2:53 pm with the MDS Coordinator. The MDS coordinator stated she was responsible for creating and updating care plans. She stated goals and interventions for wander/elopement should be included in Resident #13's care plan and was not sure why it was not. An interview was conducted on 3/7/2024 at 2:12 pm with the Administrator. The Administrator stated the MDS Coordinator was responsible for completing resident-specific care plans with goals and interventions. She stated a care plan should include goals and interventions for wander/elopement if a resident wore a wander/elopement alarm. She was unaware that Resident #13's care plan did not include goals and interventions for wander/elopement and indicated that it should have. 50046 4.) Resident #20 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment 1/6/2024 indicated Resident #20 was cognitively impaired and had received anticoagulant and psychotropic medications. The MDS also indicated Resident #20 had exhibited physical and verbal behaviors. Review of Resident #20's physician orders from January 2024 through March 7, 2024, revealed he had an active order for daily apixaban (a blood thinning medication), quetiapine (an antipsychotic medication), and trazodone (an antidepressant medication). Review of Resident #20's current Care Plan dated 1/14/24 did not reveal a care plan for monitoring anticoagulant or psychotropic medications, or behaviors. An interview was conducted with the Minimum Data Set Nurse (MDS Nurse) on 3/6/24 at 3:15 PM. She stated if a resident was receiving anticoagulant or psychotropic medications, there should be care plans addressing their use and for monitoring behaviors. The MDS nurse reviewed the care plans for Resident #20 and verified there were no care plans for anticoagulant or psychotropic medication use or behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/7/24 at 11:45 AM with the Administrator and the Director of Nursing (DON). They both stated if a resident received anticoagulant or psychotropic medications, they should have care plans in place which include monitoring. The Administrator explained this had been an oversight. 5.) Resident #259 was admitted to the facility on [DATE] The Admission Minimum Data Set assessment dated [DATE] indicated Resident #259 was cognitively impaired and had received antianxiety and antidepressant medications. Review of Resident #259's physician order dated 2/12/24 revealed she had active orders for as needed alprazolam (antianxiety medication) and daily escitalopram (antidepressant medication). Review of Resident #259's current Care Plan 2/12/24 did not reveal a care plan for monitoring psychotropic medications. An interview was conducted with the Minimum Data Set Nurse (MDS Nurse) on 3/6/24 at 3:15 PM. She stated if a resident was receiving psychotropic medications, there should be care plans addressing their use. The MDS nurse reviewed the care plans for Resident #259 and verified there were no care plans for psychotropic medication use. An interview was conducted on 3/7/24 at 11:45 AM with the Administrator and the Director of Nursing (DON). They both stated if a resident received psychotropic medications, they should have care plans in place which include monitoring. The Administrator explained this had been an oversight.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on observations, record review, and staff interviews the facility failed to secure a mechanical lift and wheelchair during a transfer for 1 of 2 residents reviewed for Accidents (Resident #38). Findings included: Resident # 38 was admitted to the facility on [DATE] with diagnoses which included lack of coordination, muscle weakness, and essential tremors. The Minimum Data Set (MDS) dated [DATE] revealed Resident #38 required partial to minimal assistance for sit-to-stand and toileting transfer, had no impairment of upper and lower extremities, did not require the use of a mechanical lift, and was severely cognitively impaired. Resident #38's care plan dated 1/11/2024 did not include goals or interventions for using a mechanical lift. An observation was conducted on 3/5/2024 at 2:43 pm of Resident #38 as he received incontinence care. Nurse Aide (NA) #1 and NA #2 were observed as they transferred Resident #38 from his wheelchair to the toilet using a mechanical lift. As Resident #38 was moved from a sitting to standing position using the mechanical lift, the wheels on both the mechanical lift, the wheelchair remained unlocked, the NAs did not steady the lift or the wheelchair. Resident #38 was transferred to the toilet and NA #1 was observed lowering the lift without locking the wheels on the mechanical lift. After incontinence care was performed by NA #2, Resident #38 was raised using the mechanical lift by NA #1 and the wheels remained unlocked. Resident #38 was then transferred back to his wheelchair using the mechanical lift. As he was lowered back into his wheelchair, the wheels on both the mechanical lift and the wheelchair remained unlocked, and NAs were standing away from the lift and wheelchair during the process of raising and lowering the lift. An interview was conducted on 3/5/2024 at 2:47 pm with NA #1. NA #1 reported she typically worked on Resident #38's hall during the dayshift (7:00 am to 3:00 pm) and verbalized she had received education on using a mechanical lift and transferring residents. NA #1 verbalized she was aware that wheels on both the mechanical lift and wheelchair should be locked during a transfer. She reported she did not think that it was necessary because there were two NA's present during the transfer. NA #1 verbalized she would have used the locks on the lift and wheelchair if she had been doing the transfer by herself. An interview was conducted on 3/5/2024 at 2:52 pm with NA #2. NA #2 reported that while using a lift and transferring residents, the wheels on both the wheelchair and mechanical lift should be locked. NA #2 verbalized the wheels were not locked because two NA's were present during the transfer. She reported she would have locked the wheels on the lift and wheelchair if she was by herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 3/6/2024 at 10:54 am with the Director of Nursing (DON). The DON reported all staff completed competency checks when they were hired and annually. She reported NA's are educated about the use of mechanical lifts and transfer of residents, which included locking the wheels on the mechanical lift and wheelchair prior to transferring the resident. The DON confirmed that NA #1 and NA #2 received education on mechanical lifts. An interview was conducted on 3/6/2024 at 5:16 pm with the Staff Development Coordinator (SDC). The SDC reported NA's completed competency checks, which included the use of mechanical lifts and transferring residents, upon hire. She verbalized staff were educated about locking the wheels on the mechanical lift and wheelchair during transfers. An interview was conducted on 3/7/2024 at 2:18 pm with the Administrator. The Administrator stated staff received education about mechanical lifts and transfers upon hire and on an as needed basis. She stated staff had received education about locking the wheels of a mechanical lift and wheelchair during transfers.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review and staff interviews the facility failed to provide a stop date for an psychotropic medication that was prescribed as needed for 2 of 2 residents reviewed for unnecessary medications (Resident #210 and #259). Findings included: 1) Resident #210 was admitted to the facility on [DATE] with a diagnosis of delirium. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #210 was prescribed antipsychotic medications, was cognitively intact, and had not exhibited any behaviors. Resident #210 was prescribed Seroquel (antipsychotic medication) 12.5 milligrams every 12 hours as needed for behaviors on 2/15/2024 with no end date. A review of the Pharmacist's Medication Regimen Review dated 2/21/2024 was conducted. The Pharmacist had recommended discontinuing the as needed order for Seroquel by 2/29/2024. A review of Resident #210's Electronic Medication Administration Record (EMAR) revealed Seroquel 12.5 milligrams every 12 hours as needed for behaviors was active from 2/15/2024 through 3/5/2024. An interview was conducted on 3/6/2024 at 9:33 am with Nurse #1. Nurse #1 stated residents who received antipsychotics were monitored for behaviors. He reported antipsychotics normally had an end date of 90 days or were indefinite. Nurse #1 reported he typically did not see end dates with Seroquel. He was unaware Resident #210's Seroquel order did not have a stop date. An interview was conducted on 3/7/2024 at 10:55 am with the Pharmacist. The Pharmacist stated she was aware that Resident #210 had an active as needed order for Seroquel with no stop date. She reported that she had sent a recommendation on 2/21/2024 to the facility to stop the as needed order for Seroquel after 14 days (2/29/2024). An interview was conducted on 3/6/2024 at 10:32 am with the Director of Nursing (DON). The DON stated residents prescribed antipsychotic medications should be monitored for behaviors and antipsychotic medications ordered on an as needed basis required a 14 day stop date. She was unaware Resident #210's as needed Seroquel order did not have an end date. An interview was conducted on 3/7/2024 at 2:03 pm with the Administrator. The Administrator stated residents who were prescribed as needed antipsychotic medications required a 14 day stop date. She reported she was made aware on 3/5/2024 Resident #210 had an antipsychotic medication ordered with no stop date and had the issue addressed. 50046 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) Resident #259 was admitted to the facility on [DATE] with diagnoses that included: depression, anxiety, and unspecified dementia without behavioral disturbances. Review of Resident #259's Care Plan dated 2/12/24 revealed Resident #259 did not have a care plan for psychotropic medication use or behaviors. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #259 was cognitively impaired and coded for antianxiety and antidepressant medication use. The MDS Indicated Resident #259 did not have any behaviors or rejection of care. Review of Resident #259's physician order dated 2/12/24 revealed an order for Alprazolam (antianxiety medication) 0.25 mg every 24 hours as needed (PRN) for anxiety. The physician's order did not contain a stop date for the medication. Review of Resident #259's electronic Medication Administration Record (eMAR) for the month of February 2024 revealed she received doses of Alprazolam on 2/18/24, 2/27/24, and 2/28/24. An interview was performed with Nurse #1 on 03/06/24 at 9:33 AM. Nurse #1 stated there was usually an end date for PRN psychotropic medications that was usually 90 days or indefinite. On 03/06/24 at 10:32 AM an interview was completed with the Director of Nursing (DON). The DON stated PRN psychotropic medications should have a stop date and the stop date should be 14 days. An interview was conducted on 03/06/24 at 5: 22 PM with the Medical Director. He stated PRN psychotropic medications should have a stop date and the stop date should be 14 days. He stated he reviewed psychotropic medications during resident visits. He explained if he found a psychotropic medication that did not have a stop date, he would add a stop date or would discontinue the psychotropic medication whenever able. He stated the pharmacy did a wonderful job reviewing psychotropic medications for 14 day stop dates. He verbalized the nurses would also monitor for stop dates on psychotropic medications and notified him when they saw a PRN psychotropic medication that needed a stop date. An interview was performed on 3/7/24 at 3:45 PM with the Administrator. The Administrator explained that PRN psychotropic medications should have a stop date. She stated the stop date for PRN psychotropic medications should be 14 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49055 Based on observations and staff interviews, the facility failed to secure resident medications left in an unattended medication cart for 1 of 2 medication carts (Dogwood Avenue medication cart). The findings included: A continuous observation of Dogwood Avenue was conducted on 03/04/24 from 11:51 am to 11:57 am. The Dogwood Avenue medication cart was observed with the lock not engaged as evidenced by the red dot on the lock being visible. There was no staff member at the medication cart. Several staff members, residents, and visitors were observed walking past the medication cart. On 03/04/24 at 11:57 am, Nurse #2 was observed approaching the Dogwood Avenue medication cart. An observation and interview were completed with Nurse #2 upon her return to the Dogwood Avenue medication cart. She placed her key in the unengaged lock and was stopped by the surveyor. The surveyor asked Nurse #2 to open the medication cart drawer prior to turning the key, and the drawer opened. The observation revealed various prescribed and over-the-counter medications and supplies, including eye drops, injectables, and oral medications for the residents on her unit. Nurse #2 explained that her normal practice was to lock the medication cart when she was not in its presence. She continued to explain that she would have pressed the lock in, ensured that the computer screen was locked, and kept the medication cart keys in her pocket at all times. Nurse #2 reported that she was not certain why she did not engage the lock when she stepped away from the medication cart. An interview with the Director of Nursing (DON) on 03/06/24 at 3:32 pm was completed. The DON reported that the medication cart should have been secured and locked unless the nurse was present at the cart. She stated that staff who noticed that the cart was unlocked should have immediately pressed the lock. Then, that staff member should have notified the nurse assigned to the cart that the unattended medication cart was unlocked. The DON verbalized that the nurse to which the medication cart was assigned was responsible for the medication cart and ensuring that it was secured.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50045 Based on observations, record review and staff interviews the facility failed to maintain a clean ice cream freezer, label and date perishable food items stored in the walk-in cooler, and label and date perishable items in the reach-in refrigerator and ensure frozen items were sealed in the walk-in freezer. These practices had the potential to affect food served to residents. Findings included: 1. The initial observation of the ice cream cooler conducted on 3/4/2024 at 9:48 am revealed pink and brown-colored substances on all four walls of the cooler. An interview was conducted with the DM on 3/7/2024 at 8:51 am. She reported the ice cream cooler was cleaned and sanitized daily. The DM stated the ice cream cooler was cleaned on 3/3/2024 and must have gotten dirty after she left. An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator reported the ice cream cooler should be clean and sanitary. She was not aware of the pink and brown-colored substance on the walls of the ice cream cooler. 2. The initial observation of the kitchen was conducted with the Dietary Manager (DM) on 3/4/2024 at 9:55 am. The initial observation of the walk-in cooler contained the following: -A package of crumbled blue cheese that had been opened with no label or date. -A package of shredded white cheddar cheese that had been opened with no label or date. - A package of shredded white/yellow cheese that had been opened with no label or date. An interview was conducted with the DM on 3/7/2024 at 8:51 am. The DM stated food is to be labeled and dated after being opened. She reported she had audited all food items in the kitchen on 3/3/2024 but the dietary aides must have opened items without labeling and dating them after she left. An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator stated all opened food packages were required to have a label and date. She was not aware of the opened packages of cheese without a label or a date. 3. The initial observation of the reach-in refrigerator conducted on 3/4/2024 at 10:06 am revealed a package of sliced American cheese that had been opened with no label or date. An interview was conducted with the DM on 3/7/2024 at 8:51 am. The DM reported she had audited all food items in the kitchen on 3/3/2024 and a dietary aide must have opened the package of sliced cheese after she left. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator stated all opened food packages were required to have a label and a date. She was not aware of the opened sliced cheese without a label or a date. 4. The initial observation of the walk-in freezer conducted on 3/4/2024 at 10:10 am revealed the following: -A package of hashbrowns that had been opened with no label or date. -An unsealed bag of okra with no label or date. An interview was conducted with the DM on 3/7/2024 at 8:51 am. The DM stated opened food packages were to be sealed, labeled, and dated. She stated she was not sure why the package of hashbrowns had no label or date and why a bag of okra was unsealed without a date in the walk-in freezer. An interview was conducted with the Administrator on 3/7/2024 at 2:12 pm. The Administrator stated all opened food packages were required to have a label and a date. She was not aware of the opened package of hashbrowns had no label or date and a bag of okra was unsealed without a date in the freezer.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review, Physician, and staff interviews, the facility failed to implement an infection prevention and control program plan, failed to implement an infection surveillance plan for monitoring and tracking infections in the facility, and failed to review infection control policies annually. This practice had the potential to affect 60 of 60 residents in the facility. Findings included: The Infection Prevention and Control program policy (Revised October 2018) documented The infection prevention and control program was coordinated and overseen by the infection prevention specialist (infection preventionist), indicated Infection Control Policies should be reviewed at least annually, and Process surveillance and outcome surveillance are used as measures of the infection prevention control program (IPCP) effectiveness. The facility's infection control policy and procedure manual was provided by the administrator on entrance to the facility. The first page of the manual indicated The [NAME] Health Center has approved the following manual as its Infection Control Policy and Procedures Manual. The front page of the manual indicated Version Date April 1, 2014. The bottom of the front page indicated the policy manual had been reviewed and approved by the Medical Director, Director of Nursing, and Administrator on 5/1/2019. An interview with the IP was completed on 3/6/24 at 4:30 PM. The Infection Preventionist (IP) stated she had been assigned to the IP role since September 2023 when the prior Director of Nursing (DON) left. She was unable to explain the surveillance process for tracking/ trending of infections or completing the antibiotic line listing. The IP was unable to provide policy and procedures for the facility's infection prevention and control program plan, surveillance of infections, or a list of reportable communicable diseases. A follow up interview was conducted on 3/7/24 at 9:40 AM with the IP. She stated she completed the North Carolina State Program for Infection Control and Epidemiology (NC SPICE) training online in April of 2023. She explained she became the facility's infection preventionist in September of 2023 after the Director of Nursing (DON) left. She stated that before September 2023 the prior DON had performed infection control duties. She stated she did not have much training on how to perform infection control duties, surveillance, line listing, or tracking/ trending of infections outside of NC SPICE training class. She said that the Regional Clinical Director would send new policies to the facility when they had updates. She stated when new policies were sent to the facility the facility would mark the review date at the top of the policy and sign the policy. She explained she did not have policies, but she would ask the Regional Clinical Director to send her the policies for: The Infection Prevention and Control Program Plan, Surveillance Policy, list of reportable communicable diseases, and Antibiotic Stewardship policy. The IP stated the Administrator, and the Director of Nursing (DON) were responsible for reviewing the facility's infection control policies annually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/7/24 11:00 AM The IP provided the following policies and indicated she had received the policies from the Regional Clinical Director today: Surveillance for Infections (Revised September 2017), Infection Prevention and Control Program (Revised October 2018), Outbreak of Communicable Disease (Revised September 2022), Reporting Communicable Diseases (Revised July 2014), Reportable Disease (Revised September 2022). The IP was not able to provide a list of reportable communicable diseases. There was not a review date or reviewer signature present on any of the above policies provided. The IP stated if staff needed to access an infection control policy there was a copy of the Facility's Infection Control Policy and Procedures Manual located at the Nursing station. An Interview was conducted on 3/7/24 at 11:18 AM with Nurse #3. She was unable to locate the facility's Infection Control Poly and Procedure Manual at the nurse's station. She stated if she needed access to an infection control policy, she had to ask the IP nurse. An interview with the Medical Director was completed 3/6/24 at 5:22 PM. He stated the facility reviewed infection control during their quality assurance performance improvement meetings. He verbalized the facility notified him when an outbreak occurred. He explained the facility notified him of the COVID-19 outbreak that occurred from December 2023-January 2024 and stated he felt the facility did a good job with infection control and managing the outbreak. An Interview was performed on 3/7/24 at 11:45 AM with the Administrator and the DON. They explained the IP was responsible for reviewing infection control policies annually. The Administrator stated the facility's infection control policies and procedures should be reviewed annually and with changes. They voiced they were unaware that the facilities infection control policies and procedures were not being reviewed annually. The Administrator stated she thought the failure occurred partially due to the facility's focus on transitioning to the new electronic computer system. They voiced they were unaware the IP was not completing a line listing for tracking/ trending of infections or obtaining diagnostic results for infections. The Administrator explained she thought the process failure was a result of the IP being trained in spring 2023 and at that time the prior DON was still doing IP duties. She stated when the prior DON left, they thought the new IP new how to do infection control, since she had completed the NC SPICE training. The Administrator voiced the new IP hesitated to ask questions and this got missed with the DON transition and the facility's focus on transitioning to the new electronic computer system. She stated when the facility was transferring to the new electronic computer system, they were focused on getting everything into the new system and things that should have gotten followed up on were not overseen well. She explained the components of the facility's infection control program not being completed and in place was likely related to the IP being new to the IP role.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 50046 Based on record review and staff interviews the facility failed to develop an infection prevention and control program that established an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of the indication, dosage, and duration of use of antibiotics. This was evident in 4 of 4 monthly surveillance data reviewed (December 2023, January 2024, February 2024, and March 2024.) Findings included: On 3/7/24 the Infection Preventionist (IP) provided the policy sent to her by the Regional Clinical Director. The Policy provided titled Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes was revised December 2016. The policy documented the antibiotic stewardship program will monitor and review all clinical infections treated with antibiotics, antibiotic utilization, identify specific situations not consistent with appropriate antibiotic use, and document all resident antibiotic regimens on the facility-approved antibiotic surveillance tracking form. The policy indicated the facility- approved antibiotic surveillance tracking form should include resident name, unit/ room number, date symptoms appeared, site of infection, date of culture, name of antibiotics, start date, stop date, total days of therapy, pathogen identified, outcome, and adverse events. During an interview with the Infection Preventionist (IP) nurse on 3/6/24 at 4:30 PM. The IP stated she had been assigned to the IP role since September 2023. The IP stated she had just started using an antibiotic line listing form in January. She stated prior to January she had not completed an antibiotic line listing form. A request to see the tracking of antibiotic use in the facility from December 2023 to March 2024 revealed the IP did not have an antibiotic line listing for the month of December 2023 and had an incomplete antibiotic line listing for the month of January 2024. She stated she did not have the information for February 2024 and was currently working on the antibiotic line listing for the month of February 2024. She did not have an active current list of residents who were receiving antibiotics. During the interview she was able to search through the orders in the electronic computer system and provided a list of residents in the facility who were currently receiving antibiotics. The IP was unable to provide culture result information for residents who had received treatment for urinary tract infections. She stated if the antibiotic was started at the hospital or by a doctor's office, she did not request diagnostic or culture results. The IP nurse was unable to identify or describe the components of an antibiotic stewardship program or the infection surveillance process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345495	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Stewart Health Center	6920 Marching Duck Drive Charlotte, NC 28210

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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An Interview was performed on 3/7/24 at 11:45 AM with the Administrator and the DON. They explained they were not aware the facility did not have an active antibiotic stewardship program. They voiced that they were unaware the Antibiotic Stewardship policy was not being followed. The Administrator stated she thought the failure occurred partially due to the facility's focus on transitioning to the new electronic computer system. They voiced they were unaware the IP was not completing infection control tasks related to antibiotic stewardship, an antibiotic line listing for tracking/ trending of infections or obtaining diagnostic results for infections. The Administrator explained she thought the process failure was a result of the IP being trained in the spring 2023 and at that time the prior DON was still doing IP duties. She stated when the prior DON left, they thought the new IP new how to do infection control, since she had completed the North Carolina State Program for Infection Control and Epidemiology (NC SPICE) training. The Administrator voiced the new IP hesitated to ask questions and this got missed with the DON transition and the facility's focus on transitioning to the new electronic computer system. She stated when the facility was transferring to the new electronic computer system, they were focused on getting everything into the new system and things that should have gotten followed up on were not overseen well. She explained the components of the facility's infection control program not being completed and in place was likely related to the IP being new to the IP role.