

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Asbury Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3211 Bishops Way Lane Charlotte, NC 28215	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695</p> <p>Based on record review and staff and resident interviews the facility failed to invite a resident to participate in the planning of the resident's care for 1 of 4 residents reviewed for participation in care plan meetings (Resident # 9).</p> <p>The findings included:</p> <p>Resident #9 was readmitted to the facility on [DATE].</p> <p>Review of the electronic medical record for Resident #9 revealed a form dated 7/13/2024, addressed to the family member of Resident #9, notifying them that a care plan meeting needed to be scheduled.</p> <p>Resident #9's most recent minimum data set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact with daily decision making and had adequate hearing.</p> <p>Review of the most recent care plan revealed it had been updated in the electronic medical record on 8/27/2024, however there was no indication that there had been any involvement from Resident #9 or family members.</p> <p>Review of the medical record included no evidence that Resident #9 was invited to participate in care plan meetings or evidence of refusing to participate.</p> <p>An interview with Resident #9 completed on 10/8/2024 at 9:54 AM revealed he had not been involved in a care plan meeting and was not aware of what a care plan meeting was.</p> <p>On 10/9/2024 at 2:25 PM an interview with MDS Coordinator #1 revealed care plan meetings were set up by the Social Worker (SW) using the MDS assessment calendar to make sure the care plan meeting dates were aligned with the most recent MDS assessment. The SW would give a list of residents to the receptionist that needed a care plan meeting. The receptionist would then mail out the care plan meeting invitation to the resident's family. Upon receiving the care plan letter the family would call the SW to set up a time to meet. MDS Coordinator #1 stated all residents, especially ones that were cognitively intact, must be invited to the care plan meetings.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/9/2024 at 3:17 PM an interview was completed with SW. The SW explained when Resident #9's care plan meeting was scheduled the family member would be called and care discussed because the resident usually did not want to attend due to difficulty hearing.</p> <p>An additional interview was conducted on 10/10/2024 at 8:44 AM with the facility SW. During the interview the SW reported she usually scheduled care plan meetings on days when Resident #9 could attend. The SW further explained that all residents needed to be invited to the care plan meetings and there should be documentation in the resident electronic medical records if he or she refused to participate.</p> <p>An interview was conducted on 10/10/2024 at 10:54 AM with the Director of Nursing (DON). During the interview the DON reported all residents should be involved in care plan meetings and if the residents chose not to be involved then that should have been documented. The DON went on to say, regardless of cognition the resident needs to be invited.</p> <p>On 10/10/2024 at 2:23 PM and interview was completed with the Administrator where she revealed she expected residents, regardless of cognition, have to be invited to the care plan meetings and if the resident did not want to attend then it needed to be documented in the resident's electronic medical record.</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>49366</p> <p>Based on staff interviews and record review, the facility failed to have a Centers for Medicare and Medicaid Services (CMS)-10123 Notice of Medicare Non-Coverage letter (NOMNC) signed prior to discharge from Medicare part A services with benefit days remaining to 1 of 3 residents reviewed for SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review (Resident #307).</p> <p>Findings included:</p> <p>Resident #307 was admitted to the facility under part A Medicare services on 6/19/24.</p> <p>A review of the medical record revealed a NOMNC letter was not signed either physically or verbally by Resident #307 or their responsible party, but was signed by Social Worker #1, with the following statement Notice waived. Last covered date is 7/2/24 and discharge from the facility on 7/3/24.</p> <p>An interview was conducted with Social Worker #1 on 10/10/24 at 11:25 AM revealed she tried to have all the NOMNC forms signed either verbally or in writing but didn't have Resident #307's form signed. She stated Resident #307 wanted to speak to her husband about leaving early as her discharge was near a holiday. Resident #307 discharged a day early due to the holiday. She stated because Resident #307 left early, she signed the notice as waived and did not acquire a signature from Resident #307.</p> <p>An interview was conducted with the Administrator on 10/10/24 at 2:26 PM revealed she had the expectation that if a resident could physically sign the NOMNC form, it should be signed but if not a verbal signature from a resident or someone to sign on their behalf was appropriate.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695</p> <p>Based on record review and staff interviews the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (ARD), which was the last day of the assessment period for 1 of 4 residents reviewed for resident assessment (Resident #8).</p> <p>Findings included:</p> <p>Resident #8 was admitted to the facility on [DATE].</p> <p>A review of Resident #8's electronic medical record revealed an annual MDS assessment with an ARD of 9/11/2024 that was open and not signed completed as of 10/09/2024.</p> <p>An interview with MDS Coordinator #1 on 10/09/2024 at 2:59 PM revealed the annual MDS assessment had not been completed and signed within 14 days of the ARD. MDS Coordinator #1 went on to say the assessment had been missed and was being worked on. The MDS Coordinator #1 further explained she and MDS Coordinator #2 had been looking over the assessment schedule to ensure nothing else had been overlooked.</p> <p>On 10/10/2024 at 10:48 AM an interview was completed with the Director of Nursing (DON). During the interview the DON stated the annual MDS assessment for Resident #8 should have been completed within 14 days of the ARD date. The DON went on to say his expectation was that all MDS assessments needed to be completed in the appropriate timeframe.</p> <p>During an interview with the Administrator on 10/10/2024 at 2:23 PM she stated she expected all MDS assessments to be completed in a timely manner.</p>

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>40476</p> <p>Based on observations, record review, and staff interviews, the facility failed to have systems in place to ensure Nurse #1 received the most recent training provided by the facility for blood glucose monitors. In addition, Nurse #1 failed to demonstrate competency in following the manufacturer's instructions for the cleaning and disinfection of a shared blood glucose meter between two residents. Nurse #1 stated she knew she was supposed to use the disinfectant wipes to disinfect the blood glucose meters between residents but had just gotten nervous and forgotten. The interview with Nurse #1 further revealed she did not know the wet time, or dry time for cleaning/disinfecting the glucometer using the disinfectant wipe. The deficient practice occurred for 1 of 3 nursing staff reviewed for competent nursing staff (Nurse #1).</p> <p>Immediate Jeopardy began on 10/10/24 when Nurse #1 failed to demonstrate competency through her failure to disinfect a shared glucometer per manufacturer's instructions. Immediate jeopardy was removed on 10/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>F880</p> <p>Based on observation, record review and staff interviews, the facility staff failed to follow the manufacturer's instructions for cleaning and disinfection of a shared blood glucose meter between resident usage for 2 of 4 residents whose blood sugar levels were checked (Resident #95, Resident #207). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were no residents with a bloodborne pathogen in the facility at the time of the investigation.</p> <p>On 10/10/24 at 9:17 AM an interview was conducted with Nurse #1. She stated the facility had a skills day in 2023 and she remembered receiving training then about glucometers but since then she had not received any training on glucometers, or disinfecting glucometers. She stated she worked at the facility on a as needed (PRN) basis working one or two days during the week or month and may have just missed training if the facility had conducted one.</p> <p>A glucometer skills check dated October 2023 revealed Nurse #1 received education on glucometer care and disinfecting.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of facility documents revealed Nurse #1 attended the annual skills fair in December 2023 and received education on bloodborne pathogens including the modes of transmission and recognizing potential sources of exposure. The training also included decontamination and disinfection of glucometers using disinfectant wipes.</p> <p>A review of Blood Glucose Monitors and Control Test training attendance log, from a training conducted on 05/05/24, revealed Nurse #1 did not receive the education.</p> <p>An interview was conducted on 10/10/24 at 10:24 AM with the Director of Nursing (DON). The DON stated the Infection Preventionist was constantly providing training and education for staff however Nurse #1 worked on a PRN basis in the facility, and he felt that was why she hadn't received the most recent education regarding glucometers. The interview revealed the IP and SDC always attempted to ensure the PRN staff were receiving education however sometimes staff got overlooked.</p> <p>An interview was conducted on 10/10/24 at 9:22 AM with the Infection Preventionist. During the interview, the Infection Preventionist stated she had completed a glucometer training course on 05/05/24 for all staff. She stated after reviewing the in-service sheets she had realized Nurse #1 did not receive the training that was conducted. She stated Nurse #1 was, just missed because she was an as needed (PRN) staff member.</p> <p>The Staff Development Coordinator (SDC) was not available for an interview.</p> <p>An interview on 10/10/24 at 2:26 PM with the Administrator revealed the in-service conducted in May 2024 was supposed to be for all staff and Nurse #1 should have received the education. She stated looking back at the education log for Nurse #1 the facility should have ensured she received an updated in-service because Infection Control was a priority for the facility.</p> <p>The Administrator was notified of immediate jeopardy on 10/10/24 at 3:10 PM.</p> <p>The facility provided the following credible allegation of Immediate Jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.</p> <p>A nurse in one of the households, during observation, was found to be non-compliant in following the facility's protocol (and the manufacturer's guidelines) on disinfecting glucometers between resident use. The nurse failed to follow the processes she had been educated on in past trainings, indicating a need to routinely monitor the staff's compliance with the glucometer disinfection policy so that either additional training can be provided, or the deficient practice can be addressed from a performance standpoint. Attendance compliance with important in-service education also needs to be routinely audited, as this nurse missed the last training that was provided on glucometer disinfection.</p> <p>All nursing staff that could do a blood glucose monitoring were identified by pulling a log from Human Resources of all applicable nursing staff. This was completed on October 10th, 2024, by the Director of Nursing and the Director of Human Resources.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All residents residing in household two that could have been affected by the deficient practice were seen by the medical provider, with orders received as necessary by the practitioner's assessment. This was completed on October 11th, 2024, by the medical provider on duty.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>The nurse found to be non-compliant with the glucometer disinfection process was re-educated with return demonstration immediately, as were all nurses in the building at the time of the observation of non-compliance. This was completed on October 10th, 2024, by the Infection Preventionist, Director of Nursing, and Nursing Supervisor.</p> <p>All nursing staff that do (or could) perform glucose monitoring will be in-serviced on the glucometer disinfection process before being allowed to work. All education will be completed on or before October 14th, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, or Nursing Supervisor. All staff members will also have a skills validation performed to ensure that they can perform the disinfection appropriately. Any staff that do not receive the education and skills validation by the October 14th, 2024, date will not be allowed to work until they are compliant with the educational training. This compliance will be monitored by the Assistant Director of Nursing/Staff Development Coordinator and/or the Infection Preventionist nurse.</p> <p>All new hires for the nursing team that do (or could) perform glucose monitoring will be educated at hire (with a skills competency performed) on the glucose monitor disinfection process. This will be completed by the Assistant Director of Nursing/Staff Development Coordinator, or designee, before the new hire is allowed to take an assignment.</p> <p>All staff will be educated with a skills competency performed on the glucose disinfection process on an annual basis. This will occur annually at the December annual skills fair (or at an annual time determined by nursing leadership). Staff members found to be non-compliant with the annual training will not be allowed to return to work until compliance with education is reached. This will be completed annually by the Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, or designee.</p> <p>Alleged immediate jeopardy removal date: October 15th, 2024</p> <p>A validation of IJ removal plan was conducted on 10/16/24. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing. Audits of any newly hired staff were reviewed to ensure they had received education on glucose monitor disinfection. An observation was conducted of glucose disinfection while onsite, the staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers.</p> <p>The IJ removal date of 10/15/2024 was validated.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>40476</p> <p>Based on observations and staff interviews, the facility failed to remove expired medications available for use from the refrigerator of a medication storage room in 1 of 3 medication rooms reviewed for medication storage (Windsor medication room).</p> <p>Findings included:</p> <p>On 10/10/24 at 11:25AM during an observation of the Windsor medication room with Nurse #2 the observation yielded 81 unopened acetaminophen suppositories 650 milligram (mg) with an expiration date of 04/24 (April/2024).</p> <p>On 10/10/24 at 11:28 AM an interview was conducted with Nurse #2. During the interview she stated the refrigerator was checked daily by the nursing staff. She stated she was responsible for checking the medication room refrigerator for the household and had just missed the expiration date by mistake. Nurse #2 stated the medication had not been used in some time and that was probably why it was missed. The interview revealed the medication was available for nurses to obtain from the room and should have been discarded if it was past the date listed on the packaging.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/10/24 at 12:35 PM. The DON was informed of the findings in the medication storage room and the DON stated the facility staff had looked in both rooms a couple of days prior and had not found the expired medication. He stated the facility went by the expiration date listed on the packaging of the medication and the expired medications should have been discarded.</p> <p>An interview was conducted with the Administrator on 10/10/24 at 2:26 PM she stated the medication should have been discarded. She stated she expected nursing staff to check the expiration dates daily.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49366</p> <p>Based on record review, observations and staff interviews, the facility failed to label and date leftover food items stored for use in the dry goods storage area and walk-in cooler and failed to ensure residents' leftover food items stored in nourishment room refrigerators were labeled and dated for 2 of 6 common area refrigerators (400 and 300 Hall nourishment rooms). These practices had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>1. An initial tour of the dry good storage area and walk-in cooler occurred on 10/7/24 at 11:30 AM with the Executive Chef. The dry goods storage and walk in refrigerator were in the basement and served all neighborhoods in the facility. The following concerns were identified:</p> <p>-a bag of bowtie pasta opened 4/4/24 with a use by date of 7/4/24 stored in the dry good storage area</p> <p>-a metal pan of pork butt prepared 9/29/24 with a use by date of 10/3/24 stored in the walk-in cooler</p> <p>An interview with the Executive Chef on 10/7/24 at 11:35 AM revealed staff went through the walk-in cooler, walk-in freezer, and dry goods storage on Mondays to clean out any food items past the use by date and they had not been to the storage area yet that day.</p> <p>2. A tour of the resident common area refrigerators occurred on 10/9/24 at 12:35 PM. The following concerns were identified:</p> <p>a. Items in the 400-hall resident refrigerator opened and not labeled with a date or room number were a 46fl oz. bottle of vegetable juice and a half of an ice cream sheet cake in freezer.</p> <p>b. Items in the 300-hall resident refrigerator labeled 305 but with no date or name included two cartons of pre-hardboiled eggs which had a strong, foul odor, eight pears in cardboard cartons, six apples in bags, six frozen meals, and a 16fl oz. container of coffee ice cream. A 16oz. carton of heavy whipping cream was stored past the expiration date.</p> <p>An interview with the Dietary Manager (DM) on 10/9/24 at 3:29 PM revealed the items in the resident common area refrigerators needed to be labeled with the name of the resident and their room number. She explained there was no timeline for the use by date and the facility went by the expiration date on the item. The DM stated dietary supervisors checked the refrigerators each morning to ensure there were no items in the refrigerators out of date.</p> <p>An interview with the Administrator on 10/10/24 at 2:36 PM revealed she had the expectation that stored food should be properly labeled and dated in the facility's refrigerators and storage rooms. The Administrator stated that food left in the resident refrigerators should be thrown out if they were past the expiration date.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476</p> <p>Based on observations, record review and staff interviews, the facility staff failed to follow the manufacturer's instructions for cleaning and disinfection of a shared blood glucose meter between resident usage for 2 of 4 residents whose blood sugar levels were checked (Resident #95, Resident #207). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were no residents with a bloodborne pathogen in the facility at the time of the investigation.</p> <p>Immediate Jeopardy began on 10/10/24 when Nurse #1 was observed performing blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's instructions. Immediate jeopardy was removed on 10/15/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place.</p> <p>Findings included:</p> <p>The blood glucose meter manufacturer's instructions for cleaning and disinfecting dated 04/2023 indicated the blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. A list of Environmental Protection Agency (EPA) wipes were recommended on the cleaning instructions. Additional instructions were to read the manufacturer's instructions for the use of the wipes.</p> <p>Review of the facility policy Glucometer Disinfection revised in May 2024 read, in part, to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. The procedure for disinfecting glucometers included:</p> <ol style="list-style-type: none"> a. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single use lancet, blood glucose testing strips, disinfecting wipes. b. Wash hands c. Explain the procedure to the resident. d. Provide privacy. e. Put on gloves. f. Obtain capillary blood glucose sampling according to the facility policy. g. Remove and discard gloves, perform hand hygiene prior to exiting room. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>h. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive.</p> <p>i. Retrieve (2) disinfectant wipes from container.</p> <p>j. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer.</p> <p>k. After cleaning, use a second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturers' instructions. Allow the glucometer to dry air.</p> <p>l. Discards disinfect wipes in waste receptacles.</p> <p>m. Perform hand hygiene.</p> <p>The wipes container which was located at the nurses station read in part to disinfect nonfood contact surfaces to thoroughly wet surface, allow treated surface to remain wet for two minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for bloodborne pathogen use.</p> <p>A continuous observation of Nurse #1 was conducted from 10/10/24 at 8:54 AM through 9:17 AM and revealed the following:</p> <p>On 10/10/24 at 8:54 AM Nurse #1 gathered necessary supplies, removed the glucometer from the top of the cart and went into Resident #95's room and obtained his blood sugar. She exited the room at 9:04 AM and returned to the cart in the hall. Nurse #1 was observed placing the glucometer immediately back into the unlabeled black bag on the cart and move to the next room. No disinfecting wipes were observed on the medication cart. Nurse #1 did not disinfect the glucometer during the observation.</p> <p>At 9:06 AM Nurse 1 gathered necessary supplies, removed the same glucometer from the top of the cart and went into Resident #207's room and obtained her blood sugar. She exited the room at 9:10 AM and returned to the cart in the hall. Nurse #1 was observed placing the glucometer immediately back into the unlabeled black bag on the cart and move to the next resident room. Nurse #1 did not disinfect the glucometer during the observation.</p> <p>At 9:13 AM of Nurse #1 necessary supplies, removed the same glucometer from the top of the cart and went into Resident #49's room. The surveyor stopped Nurse #1 and asked her to return to the hallway.</p> <p>An interview and observation occurred with Nurse #1 on 10/10/24 at 9:17 AM. Nurse #1 revealed she had worked in the facility for 9 years as an as needed (PRN) nurse and she knew she was supposed to disinfect the glucometer after each use. Nurse #1 was observed cleaning the glucometer with an alcohol swab.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Asbury Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3211 Bishops Way Lane Charlotte, NC 28215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>At 9:17 AM Nurse #1 re-entered Resident #49s room to obtain his blood sugar. The surveyor stopped Nurse #1 for the second time. Nurse #1 exited Resident #49's room and entered the hallway. Nurse #1 stated she knew she was supposed to use the disinfectant wipes but had just gotten nervous and forgotten. She stated she did not know the wet time, or dry time for cleaning the glucometer using the disinfectant wipe. The interview revealed she typically cleaned the glucometer in between residents and had been instructed to do so in the past.</p> <p>An interview on 10/10/24 at 9:22 AM with the Infection Preventionist (IP) revealed each resident household had 2 glucometers to use because not all residents admitted into the facility had their own glucometer. She stated the facility was very strict on disinfecting glucometers in between use of each resident and had just provided education on glucometer cleaning and disinfecting in May 2024. The IP stated the nurses should be using the disinfectant wipes after each use of the glucometer with a wet contact time of 2 minutes using two wipes and wiping the entire surface of the glucometer. After that, the nurses are to lay the glucometer on a towel and let it dry for a duration of 2 minutes. The IP stated she had contacted the Center for Disease Control and Prevention (CDC) to ensure it was okay to use the glucometer on multiple residents. She was told the practice was acceptable if the glucometer was disinfected per the manufacturer's instructions in between each resident use. The IP indicated Nurse #1 had not received the recent training on disinfecting glucometers in May 2024. She stated Nurse #1 should have known the policy on cleaning the glucometers and followed it. The interview further revealed the use of an alcohol swab to disinfect the glucometer was not an acceptable practice. The IP stated the negative outcome that could occur from not disinfecting the glucometer between resident use included the spread of bloodborne pathogens. She stated there were no current residents in the facility with a bloodborne pathogen. The IP stated the facility did not have dedicated glucometers to each individual resident because the staff had been provided with education and training on how to disinfect the glucometers per manufacturer's instructions. She stated Nurse #1 had not been included in the recent education. The interview revealed the household observed had a total of two glucometers and Nurse #1 should have been utilizing both.</p> <p>An interview was conducted on 10/10/24 at 10:24 AM with the Director of Nursing (DON). The DON stated that the disinfecting contact time for the blood glucose meter should be two minutes. He stated the staff had been trained and he did not know why Nurse #1 didn't follow policy. The DON stated he had worked in the facility since August 2024 and the process of using a glucometer for multiple residents had not been an issue because the facility had provided education to the staff.</p> <p>An interview on 10/10/24 at 2:26 PM with the Administrator revealed that blood glucose meters should be disinfected according to the manufacturer's instructions.</p> <p>The Administrator was notified of immediate jeopardy on 10/10/24 at 3:10 PM.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.</p> <p>A nurse (Nurse #1) in one of the households, during observation, was found to be non-compliant in following the facility's protocol (and the manufacturer's guidelines) on disinfecting glucometers between resident use.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Asbury Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3211 Bishops Way Lane Charlotte, NC 28215	
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All residents residing in the building that receive blood glucose monitoring at the time of the observation of non-compliance were identified, especially those that resided in the same household where the non-compliance occurred. These residents were identified immediately after notification of the deficient practice observation, on October 10, 2024, by the Infection Preventionist and MDS nurse.</p> <p>All residents residing in household two that could have been affected by the deficient practice were seen by the medical provider, with orders received as necessary by the practitioner's assessment. This was completed on October 11, 2024, by the medical provider on duty.</p> <p>All glucometers (12 in total) that are presently in the clinical spaces in the building were disinfected immediately, per policy and manufacturer's recommendations. The brand of wipes used are [NAME] Disposable Germicidal Surface wipes. This disinfection is completed by using one wipe to wipe away any visibly soiled areas of the glucometer. Using a second wipe, the glucometer is wiped down again to disinfect, followed by two minutes of air-dry time. This was completed on October 10, 2024, by the nursing supervisor and nurses on duty</p> <p>All diagnoses of residents in the building were reviewed to ensure that no one currently has an active diagnosis of a bloodborne pathogen. This was completed on October 10, 2024, by the Infection Preventionist and Administrator.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>The policy and procedure for glucometer disinfection was reviewed and compared to manufacturer recommendations. This was completed on October 10, 2024, by the Infection Preventionist and Administrator.</p> <p>The nurse found to be non-compliant with the glucometer disinfection process was re-educated with return demonstration immediately, as were all nurses in the building at the time of the observation of non-compliance. This was completed on October 10, 2024, by the Infection Preventionist, Director of Nursing, and Nursing Supervisor.</p> <p>All nursing staff that do (or could) perform glucose monitoring will be in-serviced on the glucometer disinfection process before being allowed to work. All education will be completed on or before October 14, 2024, by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist, or Nursing Supervisor. All staff members will also have a skills validation performed to ensure that they can perform the disinfection appropriately. Any staff that do not receive the education and skills validation by October 14, 2024, date will not be allowed to work until they are compliant with the educational training. This compliance will be monitored by the Assistant Director of Nursing/Staff Development Coordinator and/or the Infection Preventionist nurse.</p> <p>The [NAME] County Communicable Disease branch was notified of the infection control breach. An update was also provided to the division on the plan in place for correction. Communication was also provided to the residents affected by the deficient practice and/or their responsible parties. Communication to the local health department and the residents/responsible parties completed on October 11, 2024, by the Executive Director (health department communication) and the Assistant Director of Nursing/Staff Development Coordinator (resident and responsible party notifications).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediate jeopardy removal date of October 15, 2024.</p> <p>A validation of IJ removal plan was conducted on 10/16/24. The facility had compiled a list of nursing staff that were responsible for blood glucose monitoring. All staff were educated on the glucometer disinfection process before being allowed to work. The facility provided an immediate in-service for Nurse #1 with a return demonstration provided. All staff members responsible for blood glucose monitoring also completed a skills validation with return demonstration to the Director of Nursing. Audits of any newly hired staff were reviewed to ensure they had received education on glucose monitor disinfection. An observation was conducted of glucose disinfection while onsite, the staff member cleaned the glucometer according to manufacturer instructions. Nursing staff interviews revealed they had received education on the disinfection of glucometers.</p> <p>The IJ removal date of 10/15/2024 was validated.</p>