STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland Terrace	2300 Aberdeen Boulevard Gastonia, NC 28054

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on observation, record review, Guardian, Podiatrist, and staff interviews, the facility failed to provide personal privacy for Resident #28 when the Podiatrist cut her toenails in the facility's day room visible to other residents. This deficient practice was for 1 of 1 resident reviewed for personal privacy (Resident #28). The findings included: Resident #28 was admitted to the facility on [DATE] with diagnoses that included dementia with mood disturbance and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #28 was severely cognitively impaired and exhibited no behaviors or rejections of care during the assessment period. An observation conducted in the facility's day room on 10/30/24 at 12:00 PM revealed there were 10 residents seated at tables around the room. Resident #28 sat in her wheelchair in the center of the room and the Podiatrist sat on the floor in front of her and cut her toenails. There was no privacy curtain or shield in place around Resident #28. Nurse Aide (NA) #1 knelt beside Resident #28 and held her hand. An interview was conducted with NA #1 on 10/30/24 at 2:10 PM. NA #1 indicated when she was assigned to make rounds with the Podiatrist, they went to the residents' rooms to provide foot care. NA #1 revealed on 10/30/24 Resident #28 was in the day room with other residents. She stated she went into the day room with the Podiatrist, and he cut Resident #28's toenails. NA #1 indicated the Podiatrist was not concerned that there were other residents in the room, so she did not think it was an issue. NA #1 revealed that she should have taken Resident #28 to her room or a private area to have her toenails cut. A phone interview was conducted with the Podiatrist on 10/30/24 at 3:30 PM. He indicated that he had been providing podiatry services to the facility for 2 years. He stated during his scheduled visits he made rounds with a staff member and provided foot care in the residents' rooms. The Podiatrist revealed on 10/30/24 NA #1 brought him to the day room where Resident #28 was sitting with other residents. He stated NA #1 did not offer to take Resident #28 to her room, so he tried to be discreet and cut Resident #28's toenails in the day room. The Podiatrist further stated he preferred residents to be in a private area that was not visible to others when he provided foot care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtland Terrace	2300 Aberdeen Boulevard Gastonia, NC 28054

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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 - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted with Resident #28's Guardian on 10/31/24 at 9:23 AM. She revealed that Resident #28 had always taken pride in her appearance and was very put together when she went out in public. She stated that Resident #28 would not have wanted to receive foot care in an area that was visible to others. The Guardian further stated if Resident #28 was cognitively intact and able to communicate her needs she would have requested to go to her room or a private area to have her toenails cut. An interview was conducted with the Director of Nursing (DON) on 10/30/24 at 2:00 PM. The DON indicated that the facility contracted with an outside company to provide podiatry services. She revealed a staff member was assigned to make rounds with the Podiatrist on the day he was scheduled to visit, and he provided foot care in the residents' rooms. She stated NA #1 was assigned to make rounds with the Podiatrist on 10/30/24. The DON revealed that she was aware Resident #28 received foot care in the day room, visible to other residents. She stated the Podiatrist and NA #1 should have taken Resident #28 to her room to cut her toenails. The DON indicated resident foot care should be provided in a private area that was not visible to others. An interview was conducted with the Administrator on 10/31/24 at 1:07 PM. She stated the facility had a contract with an outside company that provided podiatry services to the residents. She revealed on the day the Podiatrist was scheduled to visit he made rounds with an assigned staff member and foot care was provided in the residents' rooms. The Administrator indicated she was aware that the Podiatrist cut Resident #28's toenails in the day room visible to other residents. She stated Resident #28 should have been taken to her room or a private area to have her toenails cut.