STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		12/31/18

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

Electronically Signed | 12/31/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 1 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the Centers for Medicare and Medicaid Services (CMS) form 10055 to inform residents or the responsible party services were no longer covered by Medicare for 2 of 3 residents reviewed for beneficiary notices (Resident #251 and Resident #252). Findings included: Resident #251 received Medicare-A skilled services starting 07/03/18. The last covered day of Part A services was 08/15/18. Review of Resident #251's beneficiary notices revealed form CMS 10055 related to financial liability and the right to appeal for services no longer provided by Medicare was not provided to the resident or Responsible Party (RP). During an interview on 12/05/18 at 6:04 PM, the Administrator explained Resident #251 had been a long-term resident at the facility. She confirmed form CMS 10055 had not been provided to the	F 582	F 582 1.The plan for correction on this specific deficiency is as follows: " Corrective action for resident # 251 was achieved by sending the responsible party a completed copy of the CMS form #10055 along with calling the family to make sure the Resident and responsible party were still in agreement with completion of therapy services in skilled nursing Facility. Resident #252 expired on 7/19/18 at the facility. The facility acknowledges that the ABN was not sent to the family and apologizes for not doing so. 2.The process to identify other Resident potentially effected by deficiency practice. " To ensure others were not affected the Business Office Manager (BOM) audited all financial folders of residents who have remained in the facility for Advanced Beneficiary Notice (ABN) timely notice. Residents that did not have the ABN were issued form 10055 and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 2 resident or the RP. It was her expectation CMS form 10055 would be provided anytime a resident's payer source changed and the facility was responsible for notifying the resident or RP. She revealed the Business Office Manager had been in charge of providing resident notices recently resigned from the facility. 2. Resident #252 received Medicare-A skilled services starting 06/27/18. The last covered day of Part A services was 07/06/18. Review of Resident #252's beneficiary notices revealed form CMS 10055 related to financial liability and the right to appeal for services no longer provided by Medicare was not provided to the resident or Responsible Party (RP). During an interview on 12/05/18 at 6:04 PM, the Administrator explained Resident #252 had been a long-term resident at the facility. She confirmed form CMS 10055 had not been provided to the resident or RP. It was her expectation CMS form 10055 would be provided anytime a resident's payer source changed and the facility was responsible for notifying the resident or RP. She revealed the Business Office Manager had been in charge of providing resident notices recently resigned from the facility.	F 582	BOM explained that we had not done so appropriately and apologized for not issuing. " The BOM, Social worker, MDS coordinator and Therapy Manager were in-serviced by administrator on the regulation and how to properly complete an ABN on 12/12/18. 3.Monitoring Plan as followed: " To ensure that ABNs for residents converting to a long-term stay are completed prior discharge. All residents are discussed by interdisciplinary team as discharge approaches on a weekly basis. Those who require an ABN will have a completed ABN by the BOM within 72 hours prior to discharge from skilled care. " BOM will maintain a current spreadsheet of residents discharging and date of completion of ABN. Copies of all ABN will be placed in the resident□s Financial folder. " An audit of the ABN notice spread sheet will be completed weekly for 12 weeks then monthly for 9 months by administrator. A report of the finding will be compiled by the BOM weekly for 3 months then monthly thereafter for 9 months and presented to QAPI for 12 months. " This corrective action will be fully implemented by 12/31/18 4.The person will be responsible for compliance of this corrective action is the Administrator	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to repair a hole in a bathroom ceiling for 1 of 6 resident rooms (Room #119) reviewed for providing a safe and homelike environment. During an observation of the bedroom and bathroom for Resident #93 on 12/03/18 at 1:16 PM, the bathroom ceiling was noted to have a 2 inch by ½ inch hole in the ceiling. An interview with Resident #93, who was the only resident in room 119, revealed she had only used the bathroom once to take a shower several weeks before and had not seen the hole in the bathroom ceiling at that time. During an interview with the Plant Manager on 12/06/18 at 12:35 PM, he stated if there was an issue that needed attention, the nursing assistants (NA's) could enter it into the kiosk and the nursing staff, dietary, activities and housekeeping staff could enter the information into a computer-generated program that would alert him of a problem. The Plant Manager also stated he checked the computer system multiple times daily and was unaware of any holes in the ceiling for any room. A continued interview took place in the bathroom of room #119 where the Plant Manager observed the hole in the ceiling, acknowledged that it was 2 inches by ½ inch and that he had not been made aware of the hole by staff. During an interview and observation of room #119 with the Administrator on 12/06/18 at 12:53 PM, she stated she noticed the hole in the ceiling as soon as she walked into the bathroom. The	F 584	F584 1.The plan for correction on this specific deficiency is as follows: " Corrective action for the Homelike environment was completed of by the assistant Maintenance Director by repairing the hole in the bathroom ceiling of room 119 on 12/06/18. NA #4 was educated on 12/28/18 on how to use Reqqers (Our Facility Maintenance Request System) on 12/28/18. 2.The process to identify other Resident potentially effected by deficiency practice: 100% of all resident's rooms were inspected by maintenance director. This was completed by 12/31/18.All staff was educated on the use of Reqqers on 12/28/18. Any staff not educated will be educated prior to next scheduled shift. Assistant Director of Maintenance was educated on the use of Reqqers and timely completion on 12/28/18. All new hires will be educated in orientation. ¿ 3.Monitoring Plan as followed: " All rooms will be monitored weekly by the Director of Maintenance or Director of Housekeeping for 3 months then monthly for 9 months and a list compiled of the findings. Completion dates for repairs will be tracked by the maintenance Director and reviewed weekly by the Administrator for 3 months to ensure that all work orders are getting entered and completed timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 Administrator further stated she would expect some staff member to have seen this and reported it in REQQERS (computer generated program for reporting maintenance concerns) so it could be fixed. During an interview with NA #3 on 12/06/18 at 1:01 PM, NA #3 stated she had worked with Resident #93 in her room and had gone into to bathroom at least once that day and she did not see the hole in the ceiling. NA #3 stated if she had noticed the hole she would have reported it on the kiosk since that was how maintenance found out about issues that needed attending to. During an interview with NA #4 on 12/06/18 at 1:11 PM, NA #4 stated she had noticed a hole in the bathroom ceiling of Resident #93's room the previous week and had reported it to the Plant Operations Assistant Manager (POAM) verbally. She stated the POAM said okay and that he would take care of it. NA #4 stated she did not put the information in the kiosk because she liked to tell maintenance as soon as she discovered an issue, so they know about it instead of having to look through the computer system for it. NA #4 further stated that there was no one else she told about the hole other than the POAM. During an interview with the POAM on 12/06/18 at 1:16 PM, the POAM stated they had a computer system that he and the Plant Manager look at regularly and it alerts them if there is an issue that needs to be taken care of. He further stated no one had told him there was an issue in room #119 and he had not seen anything on the computer to notify him or the Plant Manager there was a hole in the ceiling.	F 584	" A list of all the findings will be compiled monthly and presented to QAPI for review and recommendation for 1 year by the Administrator. 4.The person responsible for the implementation and compliance of this plan of correction will be the Administrator. This corrective action will be fully implemented by 12/31/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 During an interview with the Staffing Coordinator (SC) on 12/06/18 at 1:45 PM, she stated that she had a quality zone that consisted of 3 rooms that she visited daily 5 days a week. She stated she would talk with the residents to see if they were ok, inspect the room and bathroom and report any concerns. She stated she had checked this room 4 times this week (Monday, Tuesday, Wednesday and Thursday) and had not seen the hole in the bathroom ceiling. She further stated there was a checkoff list that she had not been completing that addressed if the walls, floor and ceiling were in good repair.	F 584		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and outside agency interviews, the facility failed to ensure a resident who was dependent on dialysis had a plan in place for transport to and from the treatment center prior to discharge for 1 of 3 residents reviewed for safe discharge (Resident #249). Findings included: Resident #249 was admitted to the facility 06/21/18 with diagnoses which included End	F 624	F 624 Preparations for safe transfer/discharge 1.The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility staff failed to setup transportation to dialysis after discharge for resident #249. Resident #249 was scheduled for dialysis on 7/20/18. Facility arranged for outside transportation to be set up on 7/21/18.	12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 7 Stage Renal Disease dependent on hemodialysis, Alzheimer's disease, dementia, and type 2 diabetes mellitus. Review of a consent/authorization form dated 06/21/18 revealed Resident #249 had no assigned representative and was signed and initialed by the resident. The admission Minimum Data Set (MDS) dated 06/28/18 assessed Resident #249's cognitive patterns were moderately impaired. The assessment included activities of daily living which revealed limited assistance was needed for bed mobility and extensive assistance for transfers, dressing, and toilet use and independent with setup help for eating. A walker device was used for mobility. Special treatments while not a resident and when a resident showed Resident #249 received dialysis. The MDS documentation revealed Resident #249 participated in the assessment and expected to be discharged from the community with active discharge planning already occurring for the resident to return to the community. The Care Area Assessment (CAA) completed with the admission MDS identified cognitive loss/dementia and described the resident as being alert and oriented with some confusion but able to make most needs known. The CAA explained the resident was admitted to the Skilled Nursing Facility from the hospital for short term rehabilitation and intended to return home. Resident #249 required extensive assistance with transfers, dressing, toileting and little to no assistance with anything else. This dependence on others placed the resident at an increased risk for falls.	F 624	" Social service director was immediately in serviced by the Administrator on 12/5/18 on the process of preparations of safe transfers and procedures. 2.Procedure for identifying other residents for the potential to be affected by the same deficient practice " All discharges from 11/28/2018 to 12/28/2018 were audited by Administrator on 12/28/18 to ensure all discharges were prepared as a safe discharge by auditing all discharge paperwork completed by the social service director. This was completed on 12/28/18 by the administrator. 3.Procedure for implementing the plan " New process has been implemented by the administrator to the interdisciplinary team to ensure that all anticipated discharges will have a discharge summary and post discharge plan completed and discussed with the resident and the responsible party within 24 hours prior to discharge on 12/28/18. " Current staff to include, Licensed nursing and interdisciplinary team were re-educated by the staff development coordinator on ensuring the proper procedure with safely preparing a discharge or transfer. This education has been added to the new hire orientation. " A discharge log will be maintained by social services to include the completion of the discharge summary, post discharge plan and meeting with responsible party and resident ..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 8 A review of the discharge care plan dated 07/04/18 revealed the resident wanted to be discharged home. The goal was for the resident's condition to improve and continued care would no longer be indicated. Approaches to meet this goal included conduct a life conference, provide services according to care plans in an effort to enhance optimum well-being, discuss with resident/family/representative the discharge planning process, evaluate future placement setting to determine if resident's needs can be met, complete a post discharge plan and provide a copy to and review this plan with the resident. A Dialysis/Renal failure care plan dated 07/04/18 identified the potential for complications related to hemodialysis for diagnosis of chronic renal failure. Goals were to remain free from discomfort related to renal disease and to maintain adequate fluid balance. Approaches in place included communicate with the dialysis center regarding medications, diet, and labs results, coordinate care in collaboration with the dialysis center and make transportation arrangements for dialysis. Review of the Social Service Director (SSD) progress notes revealed on 07/06/18 Resident #249 attended a conference with the interdisciplinary team. The SSD asked what plans the resident had for discharge once therapy was complete. Resident #249 stated, "I want to go home as soon as possible." On 07/08/18 a note read in part the Department of Social Services (DSS) Social Worker (SW) contacted the SSD in regards to the resident's family situation. On 07/16/18 the SSD documented Resident #249 asked to speak with her about discharge plans. He was encouraged to remain in the facility or	F 624	4.Monitoring the Plan: " The administrator will audit the discharge log weekly for 12 weeks to ensure that all discharges have been prepared for a safe discharge. The log will have documentation that a discharge summary, post discharge plan and meeting with the responsible party and resident have been completed. " Effective 12/31/18 administrator will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 5.Title of person responsible for implementing the plan ¿ The administrator will be responsible for the compliance of this corrective action. This corrective action will be fully implemented by 12/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 9	F 624		

move to an assisted living. He stated he would call a cab if he had to. The SSD explained the discharge process and he agreed to have a physician face to face and have a proper discharge instead of leaving against medical advice. Home health was setup for occupational and physical therapy, nursing, and social services. The SSD explained the discharge date and the resident's information was provided. On 07/19/18 the SSD referred to electronic documentation for a discharge note.

Review of the discharge MDS dated 07/19/18 revealed Resident #249's discharge date was 07/19/18 to the community. The MDS assessed cognitive patterns were intact.

Review of the document named discharge instructions for care, revealed the section named treatments was left blank and checked none. The box for treatements required listed below was left blank. Under the section named additional instructions the documentation read: dialysis Monday, Wednesday, and Friday at dialysis center. The section named the person receiving the instructions was signed by Resident #249 on 07/19/18.

Review of a discharge summary for Resident #249 revealed the SSD documented discharged home with home health, occupational and physical therapy, and nursing. It was signed by SSD and dated 07/19/18.

Review of an invoice from an outside sourced transportation service dated 07/23/18 revealed the facility was billed on 07/21/18 for transporting Resident #249 to the dialysis center.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 10	F 624		

During an interview conducted on 12/05/18 at 8:54 AM, the SSD explained Resident #249 was admitted to the facility 07/06/18 for weakness and was there for short term rehab. The diagnoses included type 2 DM, Alzheimer's, End Stage Renal Disease, and dependence on hemodialysis three times a week. The resident was discharged 07/19/18. She assessed cognitive patterns were intact and during the assessment the resident had voiced the desire to return home. She had spoken with family members who stated they didn't want the resident to return home due to thinking it would not be safe and explained they were no longer involved with the resident's care. The resident was also being followed by a DSS SW. She was in contact with the DSS SW who agreed the resident was alert and oriented and wasn't interested in living at an assisted or skilled nursing facility. The DSS SW asked her if she thought the resident would be safe to discharge home and at that time she wasn't aware of the resident's living conditions. Resident #249 agreed to a home visit with therapy who went to assess the living conditions. She explained she had set up transport for dialysis 3 times a week and had discussed with the DSS SW who told her he would visit Resident #249 at home the day after discharge to schedule physician visits. She didn't want the resident to leave and thought he would benefit from being at the facility and encouraged him to stay. After several conversation with the resident and much deliberation with DSS SW, the Administrator, and herself the decision to discharge the resident home was made. She explained she arranged a public transport service for dialysis treatments but was unable to provide documentation related to who and when transportation for dialysis treatment would have started for Resident #249.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 11	F 624		

During an interview on 12/05/18 at 10:30 AM, the DSS SW explained he contacted the facility on 06/25/18 and spoke with the SSD who explained she would keep him updated related to Resident #249's status and gave a possible discharge date of 07/10/18. He revealed Resident #249 had been diagnosed with Alzheimer's dementia with behaviors and a previous referral had suggested someone be with the resident at all times. He had told the SSD at the facility about the family's decisions of not wanting to be involved with Resident #249's care on 07/16/18 and also discussed with the SSD it was an unsafe discharge due to there was no caretaker in the home and it would possibly be an Adult Protective Services case. She told him she would speak to the manager about the possibility of becoming a resident of the facility. When the resident was discharge home 07/19/18 he had a dialysis appointment scheduled for 07/20/18 that was missed due to no transportation. He called the county transport on 07/20/18 who weren't aware of the resident being discharge on 07/19/18 till the morning of 7/20/18. He wasn't aware of being responsible for setting up transportation prior to discharge from the facility.

During an interview on 12/05/18 at 1:12 PM, the dialysis center Clinical Manager explained Resident #249 had received dialysis treatments at the kidney center since July, 2016. He would drive himself until he was unable and that's when family started providing transportation but stopped when he was admitted to the facility. He had missed 2 treatments during the 2 years of dialysis which occurred 06/27/18 and 07/20/18. She explained on 07/20/18 a note documented by the charge nurse revealed the resident didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 12	F 624		

show up for a scheduled treatment. She called the facility who explained the resident had been discharged home. The police were notified per policy and procedure and went to the resident's home for a well check visit. The resident told the police he was waiting for a ride to dialysis. She revealed a note dated 07/23/18 documented by the dialysis center SW read in part: spoke with the DSS SW about concerns related to care and family not being involved. The Clinical Manager explained the dialysis center attempted to get transportation till the resident was placed in a facility.

An interview conducted on 12/05/18 at 2:10 PM, the SSD confirmed she was unable to find supporting documentation to show transportation to dialysis was in place for Resident #249 prior to his discharge.

During an interview conducted on 12/05/18 at 3:36 PM, the secretary at the kidney center was aware Resident #249 had missed a dialysis treatment on 07/20/18. She submitted an application for county transport services on 7/20/18. She revealed the kidney center had called DSS and spoke to the SW assigned to Resident #249 and informed him of the transportation problems to dialysis. She didn't find out the resident was discharged from the facility until 07/20/18 and that is when she submitted the request for county transport services. She explained it took a certain amount of time to process the request for transportation and that wasn't something the kidney center normally handled when a resident was discharge from a facility. She had spoken to the facility SSD and discussed the process would take 1 - 2 weeks and the kidney center doesn't provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 13	F 624		

transportation to dialysis. She did assist with application to the county but stated she had never done that before.

An interview conducted on 12/05/18 at 3:56 PM, the SSD recalled after speaking with the dialysis center she called a different transport service. She couldn't recall who she spoke with or find documentation supporting the information regarding dialysis transportation was in place prior to discharge. She felt it was a safe discharge even without verification of transport to dialysis due to a discussion with the DSS SW who told her he would follow up with the resident the day after discharge.

An interview conducted on 12/05/18 at 6:12 PM with the Administrator who explained the resident wanted to go home and had a planned discharge. She revealed the SSD knew Resident #249 was still on a dialysis schedule for treatments but she did forget to ask who would be transporting him to the treatments. The SSD realized after transporting Resident #249 home on 07/19/18 there was no plan for transportation to the dialysis center and that's when the facility called an outside transportation service company.

An interview conducted on 12/06/18 at 10:23 AM, the outside transporting company confirmed the facility had made an inquiry for their services and he would need time to find out the date he had been contacted.

On 12/06/18 at 10:25 AM via phone text the transport company provided the text received on 07/20/18 at 12:17 PM from the facility for Resident #249 to be picked up at a home address and transported to the dialysis center on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 14 07/21/18 and 7/23/18. During an interview on 12/06/18 at 2:04 PM, the facility Medical Doctor revealed it was his expectation the facility would be aware of a plan for providing transporttion of a resident dependent on hemodialysis prior to being discharged home. During an interview on 12/06/18 at 2:39 PM, the Director of Nursing explained once the facility became aware of the missed dialysis treatment, it was rescheduled and transportation was provided the next day. She revealed it was her expectation there would be knowledge of a plan for transporting the resident to dialysis or documentation of the arrangements and conversations related to dialysis care prior to discharging a resident to home.	F 624		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 15 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete discharge assessments for 4 of 6 residents reviewed for encoding and transmitting resident assessments (Resident #2, #5, #6, and #4).	F 640	640 Encoding and Transmitting Resident Assessments 1. The plan for correcting the specific deficiency: The deficiency occurred when MDS coordinator failed to complete a discharge assessment and failed to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 16 1. Resident #2 was admitted to the facility on 06/07/18. Record review indicated an admission assessment was completed on 06/14/18. Record review indicated a discharge assessment with return anticipated was opened for 06/20/18 but was never completed. During a concurrent interview on 12/04/18 at 5:02 PM with the MDS Coordinator, she acknowledged there was not a discharge Minimum Data Set (MDS) for Resident #2. The MDS Coordinator explained the facility had switched computer systems in July 2018 and she had been unable to access the previous computer system to complete discharges. The MDS Coordinator further indicated they had to wait for 3 months after an assessment was due for a missing assessment report from the Centers for Medicaid/Medicare Services (CMS). On 12/06/18 at 2:40 PM an interview was conducted with the Director of Nursing (DON), who stated it was her expectation for all MDS assessments to be completed and transmitted within the required time frame. 2. Resident # 5 was admitted to the facility on 06/09/18 with diagnoses that included anemia, hypertension, and hyperparathyroidism. A review of Resident # 5's most recent completed MDS revealed it was dated 06/23/18. The assessment was coded as a prospective payment system (PPS) 14-day scheduled assessment.	F 640	transmit on resident # 4 and resident #6. The discharge assessment was corrected on 12/6/18. 2. Process for identifying potential residents affected by deficient practice " All residents discharged in the last 30 days were audited by MDS coordinator 2 and all corrections needed were made to the MDS assessments by MDS coordinator 1 on 12/6/18 to ensure that all discharge assessments were completed. " MDS coordinators were educated by the regional nurse consultant on 12/27/18 on accurately encoding and transmitting resident assessments. 3. Monitoring the plan " 5 MDS assessments will be audited monthly for 3 months by MDS coordinator 2. " Effective 12/31/18 MDS coordinators will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 4. Title of the person responsible for implementing this plan: " The administrator is responsible for compliance of this corrective action. It will be fully implemented on 12/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 17	F 640		

A review of Resident # 5's face sheet indicated he was being discharged on 06/20/18.

During an interview on 12/04/18 at 5:02 PM the MDS coordinator acknowledged that there was not a completed discharge MDS assessment for Resident #5 and stated she was not aware of any specific time frames that discharge assessment had to be completed. She explained when the facility switched computer system in July, she was not able to access the older system 2-3 weeks after the switch to complete discharge tracking MDS assessment for discharged residents. She had been waiting for reports from Centers for Medicate & Medicaid Services (CMS) to identify missing discharge MDS.

On 12/06/18 at 02:40 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation for all required MDS assessments be completed and transmitted within the required time frame.

3. Resident #6 was admitted to the facility on 06/13/18 with diagnoses that included hypertension, lung cancer, muscle weakness, and respiratory failure.

A review of Resident # 6's most recent completed MDS revealed it was dated 06/20/18. The assessment was coded as an admission assessment.

A review of Resident # 6's face sheet indicated she was being discharged on 07/06/2018.

During an interview on 12/04/18 at 5:02 PM the MDS coordinator acknowledged that there was not a completed discharge MDS assessment for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 18	F 640		

Resident #6 and stated she was not aware of any specific time frames that discharge assessment had to be completed. She explained when the facility switched computer system in July, she was not able to access the older system 2-3 weeks after the switch to complete discharge tracking MDS assessment for discharged residents. She had been waiting for reports from Centers for Medicate & Medicaid Services (CMS) to identify missing discharge MDS.

On 12/06/18 at 02:40 PM an interview was conducted with the Director of Nursing (DON) who stated it was her expectation for all required MDS assessments be completed and transmitted within the required time frame.

4. Resident #4 was admitted to the facility 06/13/18.

Review of the Minimum Data Set (MDS) for Resident #4 revealed a entry tracking MDS record was completed 06/13/18 and an admissions MDS record completed 06/21/18. There were no other MDS records provided for review.

During an interview on 12/04/18 at 5:02 PM, the MDS Coordinator,RN explained Resident # 4 was discharged from the facility 06/29/18 and she was not aware of a time frame to complete the discharge assessment. She further explained the facility switched to a new electronic charting system. The old system provided a limited time to access residents' MDS information needed to complete discharge assessments. When the time frame was up the MDS Coordinator was unable to access the old system to identify residents who needed a discharge assessment. She relied on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 19 report from the Center for Medicare/Medicaid Services (CMS) to identify residents' who needed a discharge assessment. She estimated it took approximately 3 months for the CMS to report and confirmed a discharge assessment should've been completed for Resident #4. On 12/06/18 at 2:40 PM an interview was conducted with the Director of Nursing (DON), who stated it was her expectation for all MDS assessments to be completed and transmitted within the required time frame.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of discharge status and respiratory treatments for 2 of 26 sample residents (Resident #99 and Resident #302) reviewed for MDS accuracy. Findings included: 1. Resident #99 was admitted to the facility on 08/24/18 with diagnoses that included anxiety disorder, kidney failure, muscle weakness, and cognitive communication deficit. Review of progress notes dated 09/12/18 indicated Resident #99 was discharged on 09/12/18 to an assisted living facility (ALF) with discharge instructions and prescriptions reviewed	F 641	F 641 Accuracy of assessments 1. The plan for correcting the specific deficiency " The deficiency occurred because the facility failed to accurately code the MDS for resident #99 at A2100 by coding discharge status as 03, Acute Care Hospital when resident discharged to an Assisted living facility. Resident #302 had oxygen in the room but was not coded in section 0 as having oxygen. Resident did not have an order in place for oxygen with CPAP. MDS coordinator modified the assessment for resident #99 and #302 to reflect the correct coding on # 99 on 12/6/18 and # 302 on 12/7/18. Orders were clarified for resident#302□s oxygen use on DON 12/6/18	12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20 and given to Resident #99's daughter. Review of Resident #99's discharge assessment MDS dated 09/12/18 revealed section A2100 under "Discharge Status" was coded as "03 - Acute hospital". During an interview on 12/05/18 at 06:06 PM the Social Service Director (SSD) confirmed that Resident #99 was discharged to an ALF on 09/12/18. On 12/06/18 at 08:25 AM an interview was conducted with the MDS Coordinator who further confirmed that Resident #99 was discharged on 09/12/18 to an ALF accompanied by his daughter. The MDS Coordinator acknowledged that it was an error to code Resident #99's discharge status as acute hospital. She stated the correct coding should be "Community". She was not sure who had made that incorrect coding. The MDS Coordinator added she would correct the error and re-submit the correction as soon as possible. During an interview on 12/06/18 at 02:40 PM the Director of Nursing (DON) stated it was her expectation for all the MDS to be coded correctly and transmitted within the required time frame. On 12/07/18 at 05:06 PM an interview was conducted with the Administrator who stated it was her expectation for all the MDS to be coded accurately and submitted in a timely manner. 2. Resident #302 was admitted to the facility on 7/10/18 with an admitting diagnosis of Transient Ischemic Accident (TIA) and a diagnosis of Chronic Obstruction Pulmonary Disease (COPD).	F 641	2. Process to identify residents potentially affected by the same deficient practice " Section A2100 of the MDS will be audited for the period beginning 9/27/2018 to 12/27/2018 for accuracy by the MDS coordinator 2. Opportunities for improved accuracy will be corrected by the MDS Coordinator 1. " Section 0 will be audited by MDS coordinator 1 for current census on 12/27/18 for all residents who have current orders for oxygen, CPAP and BIPAP. Opportunities for improved accuracy will be corrected by MDS coordinator 2 on 12/28/18. " All residents with oxygen, CPAP and BiPap had orders audited by ADON and DON on 12/17/18 . " MDS Coordinators 1 and 2 were re-educated on 12/27/18 by regional nurse consultant on ensuring MDS accuracy with all assessments specific to diagnoses, oxygen and discharge assessments. " All licensed nurse staff were re-educated by the staff development coordinator by 12/31/18 on correctly entering oxygen, CPAP and BiPAP orders into pointclickcare. Any staff not re-educated by 12/31/18 will be re-educated prior to next shift working. 3. Process for implementing plan " Section I will be audited by MDS Coordinator 1 for 90 days for 100% of OBRA assessments. " MDS staff will be re-educated by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 21 An annual Minimum Data Set (MDS) dated 10/11/18 revealed that Resident #302 was alert and oriented with no behaviors. Resident #302 was independent with activities of daily living needed supervision with set-up for bathing. Resident #302 had an impairment on the left lower extremity. On area O for the MDS assessment CPAP (Continuous Positive Airway Pressure (used for people with a diagnosis of sleep apnea - a temporary stopping of breathing especially during sleep) was coded. An observation on 12/03/18 at 4:48 PM revealed an oxygen concentrator present in Resident #302's room. A review of the MDS dated 10/11/18 revealed oxygen was not coded under Section O for Special Procedures/Treatments, or that in Section I, Sleep Apnea G47.3 is not listed as a diagnosis. A review of the Resident Assessment Instrument (RAI) for interpreting the MDS definitions for coding in the MDS revealed that O0100C, Oxygen Therapy needs to be coded on the MDS for use with a CPAP. A review of a care plan dated 11/12/16 with the last update was on 11/06/18 revealed that Resident #302 has COPD and uses CPAP with supplemental oxygen. A review of a Physician's Order with no start date revealed CPAP placements at bedtime for Sleep Apnea. No order for supplemental oxygen. On 12/06/18 at 08:25 AM an interview was conducted with the MDS Coordinator acknowledged that it was an error to not code	F 641	Regional Nurse Consultant on 12/27/18 regarding the importance of accurately coding the MDS, specifically, discharges, active diagnoses and oxygen " All licensed nurse staff were re-educated by the staff development nurse on and all licensed nursing staff were re-educated by the staff development coordinator by 12/31/18 on entering oxygen, CPAP and BiPAP orders into pointclickcare . 4. Monitoring the plan: " Section 0 will be audited by MDS coordinator 1 with 5 MDS assessments a month for 3 months. " Section A2100 will be audited by MDS coordinator 2 with 5 MDS assessments a month for 3 months. " Section I will be audited by MDS coordinator 1 for 90 days for 100% of OBRA assessments. " The DON will audit all oxygen, BiPap and CPAP orders are entered accurately into the point click care system weekly for 12weeks. " The Regional Nurse/MDS Consultant will audit 5 assessments a month for 3 months to ensure that oxygen Is coded correctly on section 0 and that section A2100 is coded accurately for discharges " Effective 12/31/18 the minimum data set nurse (MDS) will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22 Resident #302 for oxygen. The coordinator stated she was not sure who had not coded oxygen on the MDS. The MDS Coordinator added she would correct the error and re-submit the correction as soon as possible. During an interview on 12/06/18 at 02:40 PM the Director of Nursing (DON) stated it was her expectation for all the MDS to be coded correctly and transmitted within the required time frame. On 12/07/18 at 05:06 PM an interview was conducted with the Administrator who stated it was her expectation for all the MDS to be coded accurately and submitted in a timely manner.	F 641	can modify this plan to ensure the facility remains in compliance. 5. Title of person responsible for implementing the plan " The administrator is responsible for compliance on this corrective action which will be fully implemented by 12/31/18.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and observation the facility failed to follow the care plan for placement of a bed/chair alarm for 1 of 1 resident reviewed for accidents (Resident #70). The findings included: Resident #70 was admitted to the facility on 7/06/18 with an admitting diagnosis of Fracture of the L Femur, and other diagnosis included History of Falling, Subdural Hematoma, Muscle Weakness, difficulty walking, Cognitive Communication deficit, and Alzheimer's. The quarterly Minimum Data Set (MDS) dated 10/03/18 revealed Resident #70 was alert. Resident #70 needed extensive assistance with 1	F 656	F 656 Develop and Implement Care Plan 1.The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility staff failed to implement a bed/chair alarm for resident # 70. Bed/chair alarm was immediately placed on resident #70 upon notification of findings. 2. Process to identify all other residents that have the potential to be affected by the same deficient practice Director of Nursing audited all residents who are care planned for a bed/chair	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 24 person assisting for bed mobility, transfers, locomotion on/off unit, dressing, toileting and hygiene. The resident was not steady and needed physical staff assistance to stabilize and was currently on physical therapy. The MDS further revealed a bed and chair alarm used daily as a safety device. A review of Resident #70 care plan revealed the resident had a plan dated 5/31/18 for bed/chair alarm. A review of the Physician's Order (PO) revealed an order dated 7/23/18 for a bed alarm while in bed or chair. On every shift the nurse was to check the alarm for placement and function. An observation on 12/03/18 at 3:52 PM revealed Resident #70 was in bed without a bed alarm. An observation on 12/03/18 at 4:35 PM revealed Resident #70 was in bed without a bed alarm. An observation on 12/03/18 at 5:02 PM revealed Resident #70 was in bed without a bed alarm. An interview was conducted on 12/03/18 at 5:02 PM with Nurse #4 and it was reported that the resident was assisted to bed for incontinent care and the bed alarm was found rolled up in the blanket in the chair next to the bed. It was further revealed that the bed alarm should have been on the bed while the resident was in the bed or when up in the wheelchair. An interview was conducted on 12/06/18 at 2:19 PM with Nursing Assistant #2 revealed that for fall preventions the facility uses fall mats, would keep beds in the low position, and the use of bed/chair	F 656	alarm on 12/6/18 to ensure that all residents who are care planned for a bed/chair alarm have it in place. 3.Monitoring the Plan: ¿ The staff development coordinator will re-educate all licensed and unlicensed nursing staff on the monitoring of bed/chair alarms. This will be complete on 12/31/18. ¿ All other staff will be re-educated on the monitoring of bed/chair alarms and to report any concerns or issues with the placement of all bed/chair alarms to the licensed assigned nurse. ¿ Daily audit of 100% of residents who are care planned for a bed/chair alarm will be conducted daily for 2 weeks, 3x a week for 2 weeks and weekly for 8 weeks to ensure all bed/chair alarms are in place by the Director of Nursing. Effective 12/31/18 director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. ¿ 4.Title of person responsible for implementing the plan ¿ The DON is responsible for the compliance of this corrective action. It will be fully implemented by 12/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 25 alarms. The nursing assistants get the information for residents is on their care plans. It was further revealed that the nurses communicated any doctor's order related to the use of fall mats and bed or chair alarms. An interview conducted on 12/07/18 at 11:55 PM with Nurse #3 reported she had Resident #70 on 12/03/18 completed the medication administration first and signs off all orders at that time. It was reported the order was signed off on the bed alarm when it was observed for placement that morning. Nurse #3 further reported Resident #70 was monitored when up in wheelchair during the shift for safety reasons since there was a history of falls. Nurse #3 also reported the nursing assistant help making sure all residents were safe. An interview was conducted on 12/07/18 at 1:03 PM with the Medical Director and he reported his expectations were that when he writes an order that nurses should follow the order. If there is any misunderstanding he would expect the facility to notify him for clarification. An interview was conducted on 12/07/18 at 12:48 PM with the Director of Nursing revealed the expectations is that the nursing staff would follow the doctor's order to place a bed/chair alarm on the appropriate place for the resident.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 26 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and physician interviews, the facility failed to prevent a catheter bag and tubing from dragging the floor for 1 of 1 resident reviewed for urinary incontinence (Resident #304). The findings included:	F 690	F 690 Bowel -Bladder Incontinence Catheter 1. The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility staff failed to care plan an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 27 Resident #304 was admitted to the facility on 11/19/18. The 5-day admission Minimum Data Set (MDS) was not yet completed. Resident #304 was noted to have diagnoses that included non-Alzheimer's dementia, obstructive uropathy, acute cystitis with hematuria (blood and infection of urine) and urine retention. Resident #304 was also noted to have been admitted to the facility on 11/19/18 after a hospitalization for recurring urinary tract infections. A baseline care plan dated for 11/20/18 was reviewed and indicated a focus on the urinary tract infections (UTI), indwelling catheter, bacteria in his urine and CRE (a bacterium that can cause severe infections of the blood or urinary tract). A 2nd care plan also dated for 11/20/18 identified Resident #304 had an indwelling catheter related to his obstructive uropathy. No interventions for either care plan listed having the catheter bag or tubing off the floor. During an uninterrupted observation of Resident #304 on 12/05/18 from 9:36 AM to 9:54 AM revealed he was walking in the hallway with 2 staff from the therapy department. Resident #304 was observed walking with his walker with the Physical Therapy Assistant (PTA) at his side while a Certified Occupational Therapy Assistant (COTA) was pushing his wheelchair behind him. As he was walking, Resident #304 was observed to have a catheter bag in a privacy bag under his wheelchair that was dragging on the floor as it was being pushed by the 2nd staff while he was walking with his walker his catheter tubing was dragging on the floor behind him. A continued observation revealed Resident #304 sat in his wheelchair to rest and his catheter bag and	F 690	indwelling catheter for interventions that include to keep tubing off the floor and staff failed to keep the tubing secure and not touch the floor for resident #370. Catheter tubing was immediately adjusted and secured to resident # 370. 2. Process for identifying any other resident that were possibly affected by this deficient practice. ¿ 100% audit of all catheter care plans was completed by MDS coordinator on 12/27/18. ¿ 100% was completed by director of nursing and assistant director of nursing that all catheters were placed properly secured on 12/6/18. ¿ Weekly Audits were conducted by director of nursing (DON) and the assistant director of nursing (ADON) the week 12/12/18,12/19/18 and 12/26/18 that catheters were secured properly, with a dignity bag , correct order in the point click care and care planned. ¿ Licensed, and un licensed nursing staff and staff, rehabilitation staff were re-educated by the staff development coordinator (SDC) . Completion of the re-education was completed on 12/31/18. ¿ All other staff were re-educated by the SDC on the monitoring of catheter bags and ensuring that tubing is secured and if it is not the staff were re-educated on who to notify. This re-education was completed on 12/31/18. 3. Monitoring the Plan:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 28 tubing remained on the floor until the PTA noticed it and removed it from under his wheelchair to his walker, where the catheter no longer touched the floor, but the tubing continued touching the floor. When Resident #304 rose to walk again the catheter bag and tubing was no longer touching the floor. When Resident #304 had walked to the end of the hall outside of the therapy room entrance, he sat down in his wheelchair. The PTA removed his catheter bag from the walker and put it back under the wheelchair where it was again observed to be sitting on the floor along with the catheter tubing. Then COTA was observed pushing Resident #304 in his wheelchair from the hallway into the therapy room with the covered catheter bag and the catheter tubing dragging on the floor. During an interview with the Physical Therapy Assistant (PTA) on 12/05/18 at 9:55AM, the PTA stated Resident #304 had been on therapy for about weeks and they were assisting him with working up his transfers, stepping up and down on stairs and helping him to be more mobile. The PTA also stated he was aware the catheter bag and catheter tubing was on the floor, but the tubing was excessively long, and he did not want to raise the bag too high for fear of causing a UTI or other health issues for Resident #304. The PTA further stated he had training related to infection control last year and was aware catheter bags and tubing are not supposed to be on the floor. During an interview with the COTA on 12/05/18 at 10:04 AM, she stated that she had noticed the catheter bag and tubing was on the floor at the end of the hall when the PTA moved it from the wheelchair to the walker. The COTA also stated	F 690	¿ Residents who have a catheter will be audited weekly by DON or ADON that the catheter is care planned with the appropriate interventions and secured for 4 weeks, every other week for 4 weeks and monthly for 3 months. ¿ Effective 12/31/18 the director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 4. Title of person responsible for implementing the plan ¿ The DON will be responsible for this corrective action. This corrective action will be fully implemented by 12/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 29 she had not had training regarding infection control at the facility in the past year. The COTA further stated she was not aware when Resident #304 sat in his wheelchair at the end of the hall, his catheter bag and tubing were dragging on the floor as she pushed him into the therapy room. During an interview with the Director of Nursing (DON) on 12/05/18 at 10:15 AM, she stated her expectations were for all staff to be aware of catheter bags and tubing to observe they are off the floor.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and observations, the facility failed to store resident respiratory equipment properly for 3 of 3 residents (#97, #87, and #91) reviewed for respiratory care. The findings included: 1. Resident #97 was admitted to the facility on 9/21/18 with an admitting diagnosis of Pneumonia (PNE) and had a diagnosis of Chronic Obstruction Pulmonary Disease (COPD) and	F 695	F 695 Respiratory/Tracheostomy Care and Suctioning 1. The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility staff failed to place nebulizer/cpap masks in a protective cover for resident # 97, # 87 and # 91. Resident # 97, #87 and # 91 were corrected upon notification of findings. " Licensed, and un licensed nursing	12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 30	F 695		

Shortness of Breath (SOB).

Review of Resident #97's quarterly Minimum Data Set (MDS) dated 11/19/18 revealed the resident was alert and oriented. Resident #97 required limited assistance with activities of daily living (ADL's). Further review under Special Treatments, Procedures, and Programs revealed the resident was assessed needing oxygen and respiratory care.

A review of the Physician's Orders revealed Albuterol Sulfate Nebulizer Solution, 1 vial to be administered three times a day via a nebulizer machine for SOB.

An observation on 12/03/2018 at 5:02 PM revealed that the nebulizer mask was in the top drawer next to bed not in a protective covering.

An interview on 12/03/18 at 5:02 PM with Resident #97 reported she had seen the staff change the water bottle since she had been a resident, but does not remember if they were changing the tubing.

An observation on 12/05/18 at 8:31 AM revealed the nebulizer mask was sitting on top of the drawer next to bed without a protective covering.

An interview was conducted on 12/05/18 at 5:05 PM with Nurse #9 revealed nebulizer masks were to be stored in a plastic bag then placed in the top drawer.

An observation on 12/05/18 at 5:13 PM revealed the nebulizer mask was sitting on top of drawer without a protective cover.

staff, dietary staff, activity staff, housekeeping staff, rehabilitation staff and social services staff were re-educated by the staff development coordinator (SDC) protocol regarding care of CPAP and Nebulizer masks. Completion of education was completed on 12/31/18.

2.Process to identify all residents potentially affected by this deficient practice

¿ 100% audit was completed by director of nursing (DON)and assistant director of nursing (ADON)on nebulizers, oxygen and CPAP orders, cleaning schedule, tubing changing schedule and care plans on 12/19/18 with all residents on census 12/19/18 who require a nebulizer, oxygen ,CPAP and BIPAP .

¿ 100% audit of all nebulizer and cpap masks to ensure it was properly placed in a protective bag while not in use, was completed by the DON and the ADON on 12/20/18, 12/26/18.

3. Monitoring the Plan:

¿ Residents who require nebulizers, oxygen and CPAP orders will have cleaning schedule, tubing changing schedule, care plans and that all masks are in a protective bag will be audited daily for 2 weeks, weekly for 6 weeks and monthly for 2 months by unit manager 1 and unit manager 2.

¿ Effective 12/31/18 the director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 31 An observation on 12/06/18 at 7:50 AM revealed the nebulizer mask in top drawer without a protective cover. An interview was conducted 12/05/18 at 5:00 PM with Nurse #10. Nurse #10 stated the nebulizer mask was to be placed in a bag after cleaning and allowing to air dry. An interview on 12/06/18 at 3:20 PM with the Director of Nursing (DON) revealed her expectation was for nebulizer masks to be stored in a bag when not in use. 2. Resident #91 was admitted to the facility on 11/06/18 with an admitting diagnosis of PNE. The other diagnosis include SOB, sleep apnea, and Congestive Heart Failure (CHF). A review of the physician order dated 11/6/18 revealed an order for DuoNeb Solution 3-millimeter vial four times a day to be orally inhaled via nebulizer machine for COPD. A review of the 5-day MDS dated 11/13/18 revealed the resident was alert and oriented. Further review under Special Treatments, Procedures, and Programs revealed the resident was assessed needing oxygen and respiratory care. It further revealed that Resident #91 used mechanical ventilation. An observation on 12/03/18 at 5:25 PM revealed the nebulizer mask was sitting on top of the bedside drawer without protective covering. An observation on 12/05/18 at 8:23 AM revealed the nebulizer mask was sitting on top of the bedside drawer without a protective cover.	F 695	/modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 4. Title of person responsible for implementing the plan ¿ The DON will be responsible for the compliance of this corrective action and it will be fully implemented by 12/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 32	F 695		

An observation on 12/05/18 at 12:55 PM revealed the nebulizer mask lying on top of bedside drawer with no protective cover.

An interview was conducted 12/05/18 at 5:00 PM with Nurse #10. Nurse #10 stated the nebulizer mask was to be placed in a bag after cleaning and allowing to air dry.

An interview was conducted on 12/05/18 at 5:05 PM with Nurse #9 revealed nebulizer masks were to be stored in a plastic bag then placed in the top drawer.

An interview on 12/06/18 at 3:20 PM with the Director of Nursing (DON) revealed her expectation was for nebulizer masks to be stored in a bag when not in use.

3. Resident #87 was admitted to the facility on 11/02/17 with a diagnosis of Heart Failure. The MDS dated 11/06/18 revealed Resident # 87 was alert and oriented. Further review under Special Treatments, Procedures, and Programs revealed the resident was assessed needing oxygen and respiratory care.

An observation of Resident #87 on 12/05/18 at 8:54 AM revealed the CPAP mask was lying on top of bedside drawer without a protectives cover.

An observation of Resident # 87 on 12/05/18 at 4:55 PM revealed the CPAP mask was lying on top of bedside drawer without a protective cover.

An interview was conducted 12/05/18 at 5:00 PM with Nurse #10 who stated the CPAP mask should be stored in a bag after cleaning and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 33 allowing to air dry. An interview was conducted on 12/05/18 at 5:05 PM with Nurse #9 revealed CPAP that masks were to be stored in a plastic bag then placed in top drawer. An interview on 12/06/18 at 3:20 PM with the Director of Nursing revealed her expectation was for nebulizer masks and CPAP masks to be stored in a plastic bag when not in use.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 34 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove 1 expired Humalog KwikPen and 1 bottle of expired Over-the-counter (OTC) eye drops, failed to store 2 bottles of unopened latanoprost, 1 vial of unopened insulin, and 1 unopened insulin pen properly per manufacturer's specification for 3 of 4 medication carts in the facility. The findings included: 1. a. Review of the package inserts for Humalog KwikPen, Lantus vial and Lantus Solostar pen revealed all these insulins could be stored under refrigeration at 36° to 46°Fahrenheit (F) unopened until the expiration date. Once the expiration date had passed, it should be discarded. Once the insulins were being used, they could be kept at temperatures below 86°F for up to 28 days. Discarded the insulin after 28 days even if it still had insulin in it. Review of the package insert for latanoprost revealed unopened bottle(s) should be stored under refrigeration at 36° to 46°F. Once a bottle was opened for use, it might be stored at room temperature up to 77°F for 6 weeks. During a medication storage audit conducted on 12/06/18 at 11:22 AM, a Humalog KwikPen without label opened on 10/29/18 was found in the medication cart for Unit 1 Back hall. Per Package Insert, this Humalog KwikPen should be discarded 28 days after it was opened. During an interview on 12/06/18 at 11:25 AM	F 761	F 761 Label/store drugs and biologicals 1.The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility staff failed to remove 1 expired Humalog Kwik Pen and 1 bottle of expired Over-the-counter (OTC) eye drops, failed to store 2bottles of unopened latanoprost, 1 vial of unopened insulin, and 1 unopened insulin pen properly per manufacturer's specification for 3 of 4 medication carts in the facility. The findings were immediately corrected upon notification of findings 12/6/18. " Licensed, and un licensed nursing staff were re-educated by the staff development coordinator (SDC) on 12/6/18 on protocol regarding storage of medication. 2.The process to identify other resident□s potential affected by the deficient practice ¿ 100% audit was completed by unit manager 1 and unit-manager 2 on 12/18/18 on all medication carts and medication rooms. 3.Monitoring the Plan: ¿ The completion of re-education of current staff, to include licensed nursing staff, by Staff development coordinator on the standards of pharmacy guidelines with the labeling and storage of medications was completed on 12/31/18. This education has been added to the new hire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 35 Nurse #1 acknowledged that the Humalog KwikPen had expired and should be discarded. She did not recall using this insulin in the past month. She had been instructed to check each medication before administration to avoid giving expired medication to the residents. An interview was conducted with Nurse #2 on 12/06/18 at 11:25 AM. She could not explain why the expired insulin without label was still being stored in the medication cart. She stated the third shift nurses were ordered to check their respective medication cart thoroughly each night to ensure each medications were labeled properly and free of expired medications. During an interview on 12/06/18 at 12:42 PM the Director of Nursing (DON) expected all the nurses to follow facility's policies and procedures to check medication storage rooms and carts as directed to ensure proper medication storage, labeling and free of expired medications. b. During a subsequent medication storage check conducted on 12/06/18 at 11:57 AM, 2 unopened bottles of latanoprost 0.005% eye drops, 1 unopened vial of Lantus, and 1 unopened Lantus Solostar pen were found in medication cart for Unit 2 Front hall without any refrigeration. During an interview on 12/06/18 at 12:05 PM Nurse #3 acknowledged that the above unopened eye drops and insulins should be stored in the refrigerator before opened. She could not figure out how long these unopened eye drops and insulins had been stored in the medication cart. An interview was conducted with Nurse #4 on 12/06/18 at 12:08 PM. He stated the consultant	F 761	orientation. ¿ The director of nursing educated nurse 1 , nurse 2 and nurse 3 on the process to ensure that all medications are labeled and stored per pharmacy guidelines 12/7/18. ¿ Medication Carts and Medication Storage rooms will be audited twice a week for 12 weeks by nurse 3. ¿ Effective 12/31/18 director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. ¿ 4.Title of person responsible for implementing the plan The Director of Nursing is responsible for the compliance of this corrective action. This corrective action will be fully implemented by 12/31/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 36	F 761		

pharmacist who had routinely visited the facility monthly had randomly checked at least one medication cart or storage room during each visit. As a Unit Manager (UM), he would randomly check the medication carts or storage rooms occasionally. The UM stated the facility had a system in place to ensure proper labeling, storage, and free of expired medications. He attributed the incident as improper execution of facility's medication storage procedures.

During an interview on 12/06/18 at 12:42 PM the Director of Nursing (DON) expected all the nurses to follow facility's policies and procedures to check medication storage rooms and carts as directed to ensure proper medication storage, labeling and free of expired medications.

c. During a medication storage check conducted on 12/06/18 at 12:35 PM, 1 opened bottle of over-the-counter (OTC) Systane Ultra eye drops that expired on 06/30/18 was found in medication cart for Unit 2 Back hall.

During an interview on 12/06/18 at 12:38 PM, Nurse #5 acknowledged the bottle of OTC Systane eye drops was expired and should be discarded. She stated she worked on first shift most of the time. The third shift nurses were supposed to check their respective medication cart thoroughly each night to ensure the facility was free of expired medication. She considered the incident was an isolated human error.

During an interview on 12/06/18 at 12:42 PM the Director of Nursing (DON) expected all the nurses to follow facility's policies and procedures to check medication storage rooms and carts as directed to ensure proper medication storage,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 37 labeling and free of expired medications.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		12/31/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and physician interviews, the facility failed to follow contact precautions for 1 of 3 residents observed for infection control (Resident #150). The findings included: Resident #150 was admitted to the facility on	F 880	F 880 Infection Control and Prevention 1.The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility staff failed to leavea gait belt that was used on resident # 150 who was on contact precautions in the room.The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 11/29/18 with diagnoses that included diabetes and dementia. The admission MDS was still in progress. Record review indicated Resident #150 was on contact isolation for a suspected viral infection transmitted through direct contact and characterized by a painful rash with blisters. During an observation of activities of daily living (ADL) care for Resident #150 on 12/04/18 at 10:14 AM, nursing assistant (NA) #4 was observed to use a gait belt to transfer Resident #150 from the bed to his wheelchair. NA #4 was then observed to remove the gait belt and took it with her out of the resident's room and placed it in her pocket. During an interview with Nurse #6 on 12/04/18 at 10:46 AM, the nurse assigned to Resident #150 stated he had an infection on his lower back, was on contact isolation, and was supposed to stay in his room. She further stated all the equipment being used for his care had to remain in his room until he came off contact precautions. After an observation of wound care for Resident #150 by the Wound Care Nurse (WCN) on 12/04/18 at 11:20 AM, the WCN was going to assist Resident #150 to transfer from the bed to his wheelchair. The WCN checked the bathroom of Resident #150 and was unable to locate a gait belt. The WCN stepped out of the room and returned with a gait belt with the last name of Resident #150 printed in black on the gait belt. During an interview with NA #4 on 12/04/18 at 11:42 AM, NA #4 was observed to have a gait belt around her waist and stated it was the same one	F 880	findings were immediately corrected upon notification of findings. " Licensed, and un licensed nursing staff, housekeeping, dietary, activities, social services and unlicensed staff were re-educated by the staff development coordinator (SDC) on 12/6/18 protocol regarding care of a resident and equipment of a resident who is on contact precaution. 2. Identifying all resident who have the potential to be affected ¿ Staff development audited all residents on contact precautions to ensure that all required disposable equipment was in resident rooms on 12/6/2018. ¿ On 12/31/18. current staff to include, Licensed, and un licensed nursing staff, housekeeping, dietary, activities, social services staff were re-educated by the staff development coordinator (SDC) on ensuring the proper procedure with residents who are contact precautions. This corrective action education has been added to new hire orientation. 3.Monitoring the Plan: " Assistant director of nursing will monitor all residents on contact precautions to ensure all disposable equipment needed is in the resident who is on contact precautions twice a week for 12 weeks. " Effective 12/31/18 director of nursing will report the findings of the audits and observations to the Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING _____ B. WING _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	416 N HIGHLAND STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 she had used to transfer Resident #150 after providing his ADL care earlier in the day. NA #4 stated she didn't realize the gait belt needed to stay in the room when she left and further stated she had not used it on any other resident since she used it on Resident #150. NA #4 stated she had infection control training within the past year. During an interview with the DON on 12/04/18 at 12:02 PM, the DON stated her expectations were for when a resident was on contact precautions, all equipment being used for care should stay in the room. The DON further stated Resident #150 should have had his own gait belt that remained in his room for his use only.	F 880	Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 4.Title of person responsible for implementing the plan ¿ The director of nursing will be responsible for the compliance of this corrective action and this corrective action will be fully implemented by 12/31/18.	