STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 02/11/19 through 02/14/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. event ID E7ED11.	E 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director and staff, the facility failed to implement effective measures and interventions to protect residents in the facility from being hit by a cognitively impaired resident (Resident #17) for 1 of 1 resident reviewed for abuse. Findings included: Resident #17 was admitted to the facility on 04/24/13 with diagnoses that included Traumatic Brain Injury (TBI), dementia with behavioral	F 600	The Plan of correction is not to be construed as an admission of any wrong doing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal	3/14/19

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

Electronically Signed | 03/09/2019

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F 600	Continued From page 1 disturbance, psychotic disorder with delusions, anxiety disorder, restlessness and agitation, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) dated 12/12/18 indicated Resident #17 had moderate impairment in cognition, could usually make self-understood and was able to understand others. Further review of the MDS revealed Resident #17 displayed no psychosis or other behaviors during the 7-day assessment period. Review of Resident #17's medical record for the period June 2018 to February 2019 revealed the following entries: 06/17/18 read in part, nurse received report from staff Nurse Aide (NA) regarding Resident #17 hitting another resident. Resident #17 stated the other resident was trying to come into his room, so he yelled at him and hit him. Staff removed the wandering resident from Resident #17's room. 11/17/18 read in part, Resident #17 was witnessed striking another resident in the face with his fist. Staff redirected Resident #17 away without incident. On-call nurse and Nurse Practitioner notified. Resident started on 15-minute checks with no signs of injuries noted at this time. 12/31/18 read in part, staff observed Resident #17 striking another resident multiple times with a closed fist. Resident #17 stated he was upset because the other resident stated it was his house. Residents were separated and assessed with no injuries noted. Resident #17 sent to emergency department for evaluation.	F 600	claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F 600 Free from Abuse and Neglect 1. The plan for correcting the specific deficiency " The alleged deficiency occurred when the facility failed to implement effective measures and interventions to protect residents in the facility from being hit by a cognitively impaired resident. Resident #17 is currently being followed by psychiatric services. " Licensed, and un licensed nursing staff, dietary staff, activity staff, housekeeping staff, rehabilitation staff and social services staff were re-educated by the staff development coordinator (SDC) on protocol regarding monitoring behaviors of cognitively impaired residents and examples of interventions that can be utilized should behaviors manifest. This education also included that all staff are responsible to alert the Director of Nursing or Supervisor if a cognitively impaired resident demonstrates behaviors towards another	

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F 600	Continued From page 2 Review of Resident #17's care plans, with a recent review date of 12/31/18, revealed the following problem areas: Resident #17 has the potential to be physically aggressive related to dementia, poor impulse control, anger, depression as evidenced by striking another resident. Interventions included for staff to perform 15-minute checks, stop sign on door of room to prevent other resident's from entering, and Emergency Department (ED) evaluation. Resident #17 has the potential to be verbally and physically aggressive related to mental/emotional illness and poor impulse control. Interventions included for staff to administer medications as ordered, observe and document side effect and effectiveness of medications, and intervene when Resident #17 becomes agitated and before agitation escalates, guide away from source of distress and calmly engage in conversation. Review of the facility's abuse investigations completed for the period June 2018 to February 2019 revealed no written documentation of the incidents or evidence a 24-hour initial or 5-day investigative reports were submitted to the State Agency (SA) related to the resident-to-resident altercations involving Resident #17. Review of the ED progress note dated 12/31/18 read in part, "Resident #17 does display some memory and cognitive difficulties. He was able to describe the incident which precipitated him coming to the ED. Resident #17 states he is remorseful for this behavior, regrets hitting the other resident and if he had to do it all over he would talk to staff. Given his history of TBI, he is likely at risk for impulsive behaviors and even	F 600	resident. " The Director of nursing or supervisor will visually observe resident #17 daily for 5 days, then 3x week for 3 weeks and weekly for 8 weeks to ensure behaviors are addressed timely and interventions are put into place immediately. 2. How the facility will identify other residents having the potential to be affected " An audit of current residents with cognitive impairments indicating a BIMS of 10 or lower were reviewed by the Director of Nursing and unit managers to determine if interventions were in place for those that show behaviors. 3. Measures put into place " Licensed, and un licensed nursing staff, dietary staff, activity staff, housekeeping staff, rehabilitation staff and social services staff were re-educated by the staff development coordinator (SDC) on protocol regarding interventions for behaviors of cognitively impaired residents. This education also included that all staff are responsible to alert the Director of Nursing or Supervisor if a cognitively impaired resident demonstrates behaviors towards another resident. Education began 3/11/19 and will be on-going. Current staff will be re-educated prior to working next shift and this education has been added to the new hire orientation. " The director of nursing, Assistant Director of Nursing, Unit Coordinator/Supervisor, facility consultant, and/or minimum data set nurse will visually audit and interview 5 residents	

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F 600	Continued From page 3 aggression when provoked." An interview was conducted on 02/12/19 at 10:50 AM with Resident #17. Resident #17 was unable to recall any details related to the altercations he had with other residents and voiced having no concerns with other residents in the facility. An interview was conducted on 02/13/19 at 12:45 PM with Nurse #2. Nurse #2 confirmed she was working on 12/31/18 when Resident #17 hit another resident but did not witness the incident. Nurse #2 explained Resident #17 told staff he got mad because the other resident said something he did not like so he hit him. Nurse #2 added the residents were immediately separated and Resident #17 was sent to the emergency department for a psychiatric evaluation. Nurse #2 who worked on 06/17/18 and Nurse #3 who worked on 11/17/18 were unavailable for a telephone interview. A joint interview was conducted on 02/13/19 at 1:20 PM with the Administrator and Director of Nursing (DON). The Administrator stated both he and the DON started employment with the facility in October of 2018 and were not aware of the incident that occurred in June of 2018. Both the Administrator and DON confirmed knowledge of the resident-to-resident altercations involving Resident #17 on 11/17/18 and 12/31/18. The Administrator added when informed of the altercation on 12/31/18 he instructed staff to send Resident #17 to the emergency department for a psychiatric evaluation while he went to the magistrate's office to file the necessary paperwork. The DON explained although there was no written documentation of the facility's	F 600	weekly for 4 weeks, then 3 residents per week 8 weeks to ensure interventions are in place for cognitively impaired residents that show behaviors. 4. Monitoring the plan: " The director of nursing 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. 5. Title of the person responsible for implementing the plan: " The director of nursing is responsible for implementing the plan	

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F 600	Continued From page 4	F 600		

investigation, each incident involving Resident #17 was internally investigated through discussions with staff and morning meetings to try and determine the root cause of his behavior and identify triggers that contributed to his aggression. The DON added the interventions identified were care planned and measures were put into place such as 15-minute visual checks, psychiatric referral and Medical Director (MD) review for ongoing medication management. Both the DON and Administrator stated they felt his actions were unintentional, reactive responses to the situation due to his cognitive deficit and poor impulse control related to TBI. Both the DON and Administrator further stated they felt his actions did not meet the definition of abuse which was why they did not report the altercations to the SA. The Administrator added he was not aware they were required to report incidents of resident-to-resident abuse to the SA.

The facility psychiatrist was unavailable for a telephone interview.

A telephone interview conducted on 02/13/19 at 2:10 PM revealed the Medical Director (MD) was aware of Resident #17's outbursts toward other residents and had seen him regularly for behavior management. The MD explained Resident #17 had poor short-term memory and when asked about his behaviors he usually was unable to give any details of the incident. The MD added his poor recollection made it difficult when trying to determine what could be causing his behavior. He added Resident #17 didn't understand what he was doing when reacting to a situation and was not aware of the consequences his actions caused.

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F 600	Continued From page 5 An interview was conducted on 02/14/19 at 10:34 AM with NA #3. NA #3 was familiar with the altercation on 12/31/18 involving Resident #17 but stated she did not witness the incident. NA #3 stated staff do a lot of one-on-one with Resident #17 and his aggressive outbursts have improved since his admission to the facility. She explained it was difficult to determine the triggers that precipitated his behavior as he could be very short-tempered and impulsive with his actions. NA #3 added whenever Resident #17 lashed out at others, he was able to tell you why and then quickly apologized for his behavior.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review and interviews with the Medical Director and staff, the facility failed to implement their abuse policy and procedures by not reporting 3 separate incidents of resident-to-resident altercations to the State Survey Agency for 1 of 1 resident (Resident #17) reviewed for abuse.	F 607	F 607 Develop and Implement Abuse policies 1. The plan for correcting the specific deficiency: " The Administrator and DON are no longer employed by the facility as of 3/1/19. 2. Identify other residents having the	3/14/19

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F 607	Continued From page 6 Findings included: A review of the facility policy and procedure titled "Abuse Investigation and Reporting", with a revised date of December 2016, read in part: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting: 2). Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours. 3). Alleged abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours if the alleged events have resulted in serious bodily injury; or if the events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours. Resident #17 was admitted to the facility on 04/24/13 with diagnoses that included traumatic brain injury, dementia with behavioral disturbance, psychotic disorder with delusions, anxiety disorder, restlessness and agitation, and cognitive communication deficit. Review of Resident #17's medical record for the period June 2018 to February 2019 revealed the following entries:	F 607	potential to be affected: " A review was completed by the facility interim administrator and interim Director of nursing of the previous 30 days of resident to resident altercations reports. No other resident to resident altercation reports were found to be out of compliance with reporting requirement. 3. Measure put into place " The regional nurse consultant re-educated the interim administrator and interim Director of nursing (DON) on facility policy regarding reporting allegations and the time frame required on 2/28/19. " SDC re-educated current licensed and un licensed nursing staff, housekeeping staff, dietary staff, rehabilitation staff, activity staff and leadership staff on facility policy regarding reporting allegations to include resident to resident altercations and the time frame required. Education began on 2/26/19 and will be on-going. Current staff will be re-educated prior to working next shift and this education has been added to the new hire orientation. " A log will be maintained by the administrator that documents all notifications to the State Survey Agency, including Resident name, fax cover sheet, confirmation page, allegation, date, time of discovery and time of notification. Log will be placed in binder maintained by Administrator. " The log maintained by the administrator will be reviewed by the regional nurse upon visits to ensure timely	

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F 607	Continued From page 7 06/17/18 read in part, nurse received report from staff Nurse Aide (NA) regarding Resident #17 hitting another resident. Resident #17 stated the other resident was trying to come into his room, so he yelled at him and hit him. Staff removed the wandering resident from Resident #17's room. 11/17/18 read in part, Resident #17 was witnessed striking another resident in the face with his fist. Staff redirected Resident #17 away without incident. On-call nurse and Nurse Practitioner notified. Resident started on 15-minute checks with no signs of injuries noted at this time. 12/31/18 read in part, staff observed Resident #17 striking another resident multiple times with a closed fist. Resident #17 stated he was upset because the other resident stated it was his house. Residents were separated and assessed with no injuries noted. Resident #17 sent to emergency department for evaluation. Review of the facility's abuse investigations completed for the period June 2018 to February 2019 revealed no 24-hour initial or 5-day investigative reports were submitted to the State Agency (SA) related to the resident-to-resident altercations involving Resident #17. Review of the quarterly Minimum Data Set (MDS) dated 12/12/18 indicated Resident #17 had moderate impairment in cognition, could usually make self-understood and was able to understand others. Further review of the MDS revealed Resident #17 displayed no psychosis or other behaviors during the 7-day assessment	F 607	reporting. " The regional nurse consultant will audit all resident to resident allegations weekly for 4 weeks and monthly for 2 months ensure timely reporting. 4. Monitoring the plan: " The administrator 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. 5. Title of person responsible for implementing the plan " The administrator is responsible for implementing this plan	

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F 607	Continued From page 8	F 607		

period.

An interview was conducted on 02/13/19 at 12:45 PM with Nurse #2. Nurse #2 voiced knowledge of the facility's policy regarding reporting alleged abuse. Nurse #2 confirmed she was working on 12/31/18 when Resident #17 hit another resident but did not witness the incident. Nurse #2 explained Resident #17 told staff he got mad because the other resident said something he did not like so he hit him. Nurse #2 added the residents were immediately separated and Resident #17 was sent to the emergency department for a psychiatric evaluation.

A joint interview was conducted on 02/13/19 at 1:20 PM with the Administrator and Director of Nursing (DON). The Administrator stated both he and the DON started employment with the facility in October of 2018 and were not aware of the incident that occurred in June of 2018. Both the Administrator and DON confirmed knowledge of the resident-to-resident altercations involving Resident #17 on 11/17/18 and 12/31/18. The Administrator added when informed of the altercation on 12/31/18 he instructed staff to send Resident #17 to the emergency department for a psychiatric evaluation while he went to the magistrate's office to file the necessary paperwork. The DON explained each incident was internally investigated to try and determine the root cause of his behavior and identify triggers that contributed to his aggression. The DON added the interventions identified were care planned and measures were put into place such as 15-minute visual checks, psychiatric referral and Medical Director (MD) review for ongoing medication management. Both the DON and Administrator stated they felt his actions were

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F 607	Continued From page 9 unintentional, reactive responses to the situation due to his cognitive deficit and poor impulse control related to traumatic brain injury. Both the DON and Administrator further stated they felt his actions did not meet the definition of abuse which was why they did not report the altercations to the SA. The Administrator added he was not aware they were required to report incidents of resident-to-resident abuse to the SA. A telephone interview conducted on 02/13/19 at 2:10 PM revealed the Medical Director (MD) was aware of Resident #17's outbursts toward other residents and had seen him regularly for behavior management. The MD explained Resident #17 had poor short-term memory and when asked about his behaviors he usually was unable to give any details of the incident. The MD added his poor recollection made it difficult when trying to determine what could be causing his behavior. He added Resident #17 didn't understand what he was doing when reacting to a situation and was not aware of the consequences his actions caused.	F 607		
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 review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect a fall for 1 of 3 sampled residents reviewed for falls (Resident #171) and 1 of 5 sampled residents reviewed for unnecessary medication to indicate diagnosis (Resident #23).	F 641	F641 Accuracy of Assessments 1. How corrective action will be accomplished for those residents affected by deficient practice: " On 2/12/19 MDS Nurse corrected error on assessment and sent to CMS for	3/14/19

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F 641	Continued From page 10 Findings included: 1. Resident #171 was admitted to the facility on 01/28/19 with diagnoses which included non-Alzheimer's dementia and orthostatic hypotension (decreased blood pressure when standing). A review of a care plan with an initiation date of 02/06/19 indicated Resident #171 had an identified problem of being at risk for falls related to confusion, gait/balance problems, and orthostatic hypotension. The care plan indicated Resident #171 had a fall on 02/02/19 while walking without assistance. A review of an incident accident report dated 02/02/19 indicated Resident #171 had a witnessed fall while walking to the doorway of his room and did not sustain an injury. A review of a nurse's note dated 02/02/19 indicated Resident #171 had a witness fall while walking to his doorway and fell on his bottom and did not sustain an injury. A review of the 5 day admission MDS assessment dated 02/04/19 indicated Resident #171 was not coded under Section J1900 as having had a fall since admission/entry or reentry or prior assessment. On 02/12/19 at 9:18 AM an interview was conducted with the MDS Coordinator who stated he was responsible for coding Section J1900 of Resident #171's 5 day admission MDS assessment dated 02/04/19. The MDS Coordinator stated Resident #171 had a fall in the	F 641	validation; validation was accepted. 2. How corrective action will be accomplished for other residents having the potential to be affected by the deficient practice: " Rule established by facility to review all assessments prior to transmission to ensure falls are accurately coded. Daily stand up meeting agenda item implemented as a checklist. (effective date of 2/12/19). 3. Measures that will be put in place to ensure deficient practice will not recur: " All MDS assessments completed for the week will be reviewed and checked by Resident Assessment Coordinator and Director of Rehab daily for 4 weeks followed by biweekly checks for 4 weeks followed by a monthly check for 2 months. 4. How the facility plans to monitor its performance to ensure solutions are sustained: " Administrator and DON to review during daily standup meeting □ Monday to Friday " The Resident Assessment Coordinator 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. Title of the person responsible for	

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F 641	Continued From page 11 facility on 02/02/19 during the look back period from 01/29/19 to 02/04/19 and should have been coded under Section J1900 as having had a fall. The MDS Coordinator stated he would submit a modification to the 5 day admission MDS assessment to accurately reflect Resident #171 had a fall. On 02/12/19 at 9:29 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the 5 day admission MDS assessment dated 02/04/18 would have been accurately coded to reflect Resident #171 had a fall during the look back period from 01/29/19 to 02/04/19. The DON stated her expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. On 02/12/19 at 10:17 AM an interview was conducted with the Administrator who stated his expectation was that the 5 day admission MDS assessment dated 02/04/19 would have been accurately coded to reflect Resident #171 had a fall during the look back period 01/29/19 to 02/04/19. The Administrator stated his expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. 2. Resident #23 was admitted to the facility on 12/14/18 with multiple diagnoses that included encephalopathy (disease that affects the brain structure or function), dementia with behavioral disturbance, chronic obstructive pulmonary disease (shortness of breath), and hypertension.	F 641	implementing the plan: " The Administrator and Resident Assessment Coordinator are responsible for implementing the plan.	

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	345208	A. BUILDING _____ B. WING _____	C 02/14/2019

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F 641	Continued From page 12 Review of Resident #23's medical record revealed a physician's order dated 12/14/18 for Atorvastatin Calcium Tablet (cholesterol medication) 40 milligrams to be given at bedtime for hyperlipidemia. Review of the admission Minimum Data Set (MDS) dated 12/21/18 coded Resident #23 with severe impairment in cognition. Further review of the MDS revealed hyperlipidemia was not coded as an active diagnosis. During an interview on 02/13/19 at 3:45 PM, the MDS Coordinator explained he reviewed the hospital history and physical, hospital discharge summary and the facility's physician history and physical when determining active diagnoses to code on the MDS. He confirmed the hospital history and physical indicated Resident #23 had a diagnosis of hyperlipidemia and she received Atorvasatin medication at the time of the MDS assessment. The MDS Coordinator stated he missed coding hyperlipidemia as an active diagnosis and a modification of the MDS dated 12/21/18 would be submitted. During an interview on 02/13/19 at 4:45 PM, the Director of Nursing stated she expected for MDS assessments to be accurately coded.	F 641		
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	F 656		3/14/19

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F 656	Continued From page 13 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). (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 observations, record review, and staff interviews, the facility failed to follow a care plan for 1 of 3 residents reviewed for edema (Resident	F 656	F656 Develop/Implement Comprehensive Care Plans CFR(s) 1. How corrective action will be an	

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F 656	Continued From page 14 #38). Findings included: Resident #38 was admitted to the facility on 12/31/15 with the following diagnoses: heart failure. A review of the annual Minimum Data Set (MDS), dated 01/04/19, indicated Resident #38 had severe cognitive impairment. The MDS also indicated Resident #38 required supervision with one-person physical assistance for dressing and personal hygiene. A record review of a Physician's Order, dated 01/09/19, indicated Resident #38 required knee-high support hose to be applied in the morning and removed in the evening for edema. A record review of the heart failure care plan, dated 01/09/19, indicated Resident #38 required knee-high hose to be applied to her bilateral lower extremities in the morning and removed in the evening. During an observation on 02/13/19 at 7:56 AM, Resident #38 was observed in her room, sitting in her wheelchair, facing away from the bed and had swelling to both lower extremities and was not wearing knee-high support hose. During an observation on 02/13/19 at 9:32 AM, Resident #38 was observed in her room, sitting in her wheelchair, facing away from the bed and had swelling to both lower extremities and was not wearing knee-high support hose. During an interview on 02/13/19 at 10:00 AM, a	F 656	accomplished for those residents affected by deficient practice: " On 2/14/19 silverware was taken off care plan assessments. Call button and ted hose were put On and moved to accessible position. " Ted hose orders have been added to MAR (effective 2/19/19) " Inservice was provided on expectations for call lights to be within reach of all residents. 2. How corrective action will be accomplished for other residents having the potential to be affected by the deficient practice: " Audit of all residents conducted on 2/19/19 to identify residents with potential to require Ted hose. 3. Measures that will be put in place to ensure deficient practice will not recur: " Director of Nursing to review all Ted hose orders and compliance weekly for 4 weeks followed by biweekly review for 4 weeks followed by monthly review for 2 months. 4. How the facility plans to monitor its performance to ensure solutions are sustained: " The director of nursing 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	

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F 656	Continued From page 15 nursing assistant (NA #1) who regularly cared for Resident #38 stated the resident had support hose, but she had not seen them on her. NA #1 further stated Resident #38 was supposed to wear the hose because she had swelling in her feet, but she did not know where the knee-high hose were located in Resident #38's room. During an interview on 02/13/19 at 10:27 AM, Nurse #1 stated Resident #38 did not have treatment orders for knee-high hose and she did not wear knee-high hose. During an interview on 02/13/19 at 1:01 PM, the MDS Coordinator stated Resident #38 had an order for knee-high hose written in January 2019. The MDS Coordinator further stated the order for the knee-high hose had not been transcribed on the Medication Administrator or Treatment Record as it should have been for the nursing staff to check for placement. The MDS Coordinator indicated the knee-high hose should have been placed on Resident #38 consistent with the care plan and physician order. During a telephone interview on 02/14/19 at 9:55 AM, the facility physician stated Resident #38 should be wearing the knee-high hose. He further stated it was good to have compression on her lower extremities in order to keep the swelling down because she did have peripheral vascular disease. The facility physician indicated no harm would come from Resident #38 not wearing the knee-high hose. During an interview on 02/14/19 at 1:48 PM, the Director of Nursing (DON) stated her expectation was that Resident #38 should have been wearing the knee-high hose per the physician's order and	F 656	remains in compliance. Title of the person responsible for implementing the plan: " The Director of nursing is responsible for implementing the plan	

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F 656	Continued From page 16 the care plan should have been followed for the knee-hi hose. During an interview on 02/14/19 at 2:03 PM, the Administrator stated his expectation was that Resident #38 should have been wearing the knee-high hose.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		3/14/19

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F 657	Continued From page 17	F 657		

by:
Based on record review, resident and staff interviews, the facility failed to update a care plan to accurately reflect a resident no longer received a nutritional supplement for 1 of 1 resident (Resident #67) reviewed for food and failed to update a care plan to accurately reflect a resident's Level II Preadmission Screening and Resident Review (PASRR) status for 1 of 1 resident reviewed for PASRR (Resident #12).

Findings included:

1. Resident #26 admitted to the facility on 03/30/18 with multiple diagnoses that included neurological disorder, dementia, depression and abnormal weight loss.

Review of the physician orders for Resident #26 revealed an order dated 06/06/18 for House 2.0 (nutritional supplement) 60 milliliters (ml) twice daily that was discontinued on 11/28/18. Review of the Medication Administration Records (MAR) for December 2018, January 2019 and February 2019 revealed House 2.0 was not administered to Resident #26.

Review of the quarterly Minimum Data Set (MDS) dated 01/02/19 indicated Resident #26 was coded with moderate impairment in cognition and required supervision with set-up assistance for eating. Further review of the MDS revealed Resident #26 had no significant weight loss or gain during the assessment period.

Review of Resident #26's nutrition care plan, last reviewed on 01/10/19, identified the problem area for potential weight changes related to MS and dementia. Interventions included for staff to

F657 CARE PLAN TIMING AND REVISION
1. How corrective action will be accomplished for those residents affected by deficient practice:
" On 2/14/19 Resident Assessment Coordinator corrected error and revised care plan to reflect that resident#67 was no longer taking the Med Pass supplement. Resident#12 care plan was updated to reflect correct PASRR status by Resident Assessment Coordinator.

2. How corrective action will be accomplished for other residents having the potential to be affected by the deficient practice:
" Nutritional Care plans and PASSR care plans were reviewed by Director of Nursing and Resident assessment coordinator to ensure that supplement interventions were accurate as well as PASRR status and interventions. No other residents found affected at this time.

3. Measures that will be put in place to ensure deficient practice will not recur:
" Physicians orders will be reviewed daily in the morning clinical meeting by the Director of Nursing and Resident Assessment Coordinator Monday to Friday to ensure that supplements have been appropriately updated on the resident□s care plan. PASRRs for new admissions or Resident Reviews completed for existing residents will be reviewed as well by the Director of Nursing and the Resident Assessment

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F 657	Continued From page 18 administer House 2.0 60 ml twice daily. During an interview on 02/13/19 at 3:45 PM the MDS Coordinator confirmed he was responsible for updating resident care plans. The MDS Coordinator confirmed the order for House 2.0 for Resident #26 was discontinued on 11/28/18 and should have been removed as an intervention on his care plan. The MDS Coordinator stated it was an oversight and the care plan would be updated. During an interview on 02/13/19 at 4:45 PM the Administrator stated it was his expectation for care plans to be accurate and updated as needed. 2. Resident #12 was admitted to the facility 2/20/15 with diagnoses which included anxiety, manic depression, and psychotic disorder other than schizophrenia. The quarterly Minimum Data Set (MDS) dated 12/05/18 revealed that Resident #12 was cognitively intact. She was coded as requiring extensive assistance with most of her activities of daily living and a Level I Preadmission Screening and Resident Review (PASRR). A review of the care plan initiated 1/18/18 for Resident #12 revealed the resident had a Level II PASRR related to mental illness. An interview with the MDS Coordinator on 2/13/19 at 4:42 PM revealed Resident #12 was not a PASRR Level II. The MDS Coordinator further revealed the care plan intervention was in error. An interview with the Director of Nursing (DON)	F 657	Coordinator in the morning clinical meeting Monday to Friday to ensure that PASRRs and any completed Resident Reviews have been appropriately updated on the resident□s care plan. This will be completed daily for 4 weeks followed by biweekly checks for 4 weeks followed by a monthly check for 2 months. 4. How the facility plans to monitor its performance to ensure solutions are sustained: " The director of nursing and Resident Assessment Coordinator 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. Title of the person responsible for implementing the plan: " The Director of Nursing and Resident Assessment Coordinator are responsible for implementing the plan.	

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F 657	Continued From page 19 on 2/13/19 at 4:53 PM revealed it was her expectation that the care plan was accurate for all residents. An interview with the Administrator on 2/13/19 at 4:53 PM revealed it was his expectation that the care plans accurately reflect the needs of the residents.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow a physician's order regarding knee-high support hose for 1 of 2 residents reviewed for edema (Resident #38). Findings included: Resident #38 was admitted to the facility on 12/31/15 with the following diagnoses: heart failure. A review of the annual Minimum Data Set (MDS), dated 01/04/19, indicated Resident #38 had severe cognitive impairment and required supervision with one-person physical assistance for dressing and personal hygiene. A record review of a Physician's Order, dated 01/09/19, indicated Resident #38 required knee-high support hose to be applied in the	F 658	F658 Services Provided Meet Professional Standards CFR(s) 1. How corrective action will be accomplished for those residents affected by deficient practice: " On 2/14/19 the order for TED hose orders was added to MAR. " TED hose was provided to the resident. " Staff educated on expectation that daily HOSE use required for resident. 2. How corrective action will be accomplished for other residents having the potential to be affected by the deficient practice: " Audit conducted for all residents by Director of Nursing and Regional Nurse Consultant to capture any other residents for potential of need for TED hose. No	3/14/19

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F 658	Continued From page 20 morning and removed in the evening for edema. A record review of the heart failure care plan, dated 01/09/19, indicated Resident #38 required knee-high hose to be applied to her bilateral lower extremities in the morning and removed in the evening. During an observation on 02/13/19 at 7:56 AM, Resident #38 was observed in her room, sitting in her wheelchair, facing away from the bed and had swelling to both lower extremities and was not wearing knee-high support hose. During an observation on 02/13/19 at 9:32 AM, Resident #38 was observed in her room, sitting in her wheelchair, facing away from the bed and had swelling to both lower extremities and was not wearing knee-high support hose. During an interview on 02/13/19 at 10:00 AM, nursing assistant (NA) #1 who regularly cared for Resident #38 stated the resident had support hose, but she had not seen them on her. NA #1 further stated Resident #38 was supposed to wear the hose because she had swelling in her feet, but she did not know where the knee-high hose were located in Resident #38's room. During an interview on 02/13/19 at 10:27 AM, Nurse #1 stated Resident #38 did not have treatment orders for knee-high hose and she did not wear knee-high hose. During an interview on 02/13/19 at 1:01 PM, the MDS Coordinator stated Resident #38 had an order for knee-high hose written in January 2019. The MDS Coordinator further stated the order for the knee-high hose had not been transcribed on	F 658	other residents found affected at this time. 3. Measures that will be put in place to ensure deficient practice will not recur: " Director of Nursing and Nurse managers to review all TED hose orders in the morning clinical meeting Monday to Friday to ensure compliance weekly for 4 weeks then biweekly for 4 weeks, then monthly for 2 months. " Director of Nursing and Nurse Managers will randomly audit once per week for 4 weeks, then monthly for 2 months to ensure that TED hose interventions are being utilized as ordered. 4. How the facility plans to monitor its performance to ensure solutions are sustained: " The Director of Nursing 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. Title of the person responsible for implementing the plan: " The Director of nursing and Administrator are responsible for implementing the plan	

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F 658	Continued From page 21 the Medication Administrator or Treatment Record as it should have been for the nursing staff to check for placement. The MDS Coordinator indicated the knee-high hose should have been placed on Resident #38 consistent with the care plan and physician order. During a telephone interview on 02/14/19 at 9:55 AM, the facility physician stated Resident #38 should be wearing the knee-high hose. He further stated it was good to have compression on her lower extremities in order to keep the swelling down because she did have peripheral vascular disease. The facility physician indicated no harm would come from Resident #38 not wearing the knee-high hose. During an interview on 02/14/19 at 1:48 PM, the Director of Nursing (DON) stated her expectation was that Resident #38 should have been wearing the knee-high hose per the physician's order. During an interview on 02/14/19 at 2:03 PM, the Administrator stated his expectation was that Resident #38 should have been wearing the knee-high hose.	F 658		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803		3/14/19

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F 803	Continued From page 22 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide large portions per the resident's food preference for 1 of 1 resident (Resident #26) reviewed for food. Findings included: Resident #26 admitted to the facility on 03/30/18 with multiple diagnoses that included neurological disorder, dementia, depression and abnormal weight loss. Review of Resident #26's recorded weights for the period November 2018 to February 2019 revealed the following: 11/08/18 157 pounds (lbs.) No weight recorded for December 2018. 01/02/19 153 lbs. 02/02/19 148 lbs.	F 803	F803 Menus Meet Resident Needs/Prep in Advance/Followed CFR(s) 1. The plan for correcting the specific deficiency: " Resident #26 has been given larger portions as requested beginning 2/14/19. Meal card for this particular resident has been updated. " Dietary manager and Registered Dietician have agreed to review food preferences lists at regularly scheduled visits by Registered Dietician. 2. How the facility will identify other residents having the potential to be affected: " On 2/25/19 a 100% audit of all resident food preferences was conducted to ensure accuracy of resident meal tickets.	

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	345208	A. BUILDING _____ B. WING _____	C 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 803	Continued From page 23 Review of the quarterly Minimum Data Set (MDS) dated 01/02/19 indicated Resident #26 was coded with moderate impairment in cognition and required supervision with set-up assistance for eating. Further review of the MDS revealed Resident #26 had a recorded weight of 153 lbs. with no significant weight loss or gain during the assessment period. Review of Resident #26's medical record revealed an undated food preference list signed by the Registered Dietician (RD) that indicated Resident #26 liked all foods and preferred larger portions at breakfast, lunch and dinner. During an interview on 02/11/19 at 4:10 PM Resident #26 voiced no concerns with the quality, taste or temperature of the food but indicated he did not receive enough to eat at meals and would like larger portions. During an observation and follow-up interview on 02/13/19 at 8:30 AM Resident #26 was sitting up in bed finishing breakfast. Observation of Resident #26's meal card revealed larger portions was not listed and he was served one biscuit, one sausage patty, a portion of oatmeal and scrambled eggs. Resident #26 stated he ate all but the scrambled eggs which he did not like. Resident #26 stated he "was not starving, just hungry after meals." He added breakfast was usually sufficient but would prefer larger portions with lunch and dinner. During an interview on 02/13/19 at 9:50 AM the Dietary Manager (DM) stated she was unaware Resident #26 requested larger portions at each meal. The DM reviewed the undated food	F 803	3. Measures put into place: " Dietary manager to review meal tickets weekly to safeguard against errors and improve patient centered care. " On 3/13/19 education began to Licensed and non-licensed nursing staff by SDC on Documentation and communication to be made when appropriate to the dietary manager if a resident preference needs to be updated. Education is on-going and Current licensed and non-licensed nursing staff will be re-educated prior to working next shift and this education has been added to the new hire orientation. Updated preferences will be given to Dietary manager. " Weekly audit form to be given to Administrator showing changes/corrections made to dietary preferences for 4 weeks. " Dietary Manager will conduct random audit on 4 residents monthly for 2 months to ensure that preferences are provided. " Checklist added to Weights Meeting to review any preference changes. " Preferences of residents to be taken quarterly by Dietary Manager and updated as necessary. 4. Monitoring the plan: " Dietary Manager 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	

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F 803	Continued From page 24 preference list signed by the RD and confirmed large portions were not currently indicated on his meal card. She was unable to recall the exact date but stated the RD was at the facility in January 2019 and they were working together to update all residents' food preferences. She added the RD must have forgotten to inform her of Resident #26's request for larger portions. During a telephone interview on 02/13/19 at 4:29 PM the RD explained she had not been working at the facility for very long and was still trying to familiarize herself with the residents in the building. She recalled she was at the facility sometime in January 2019 and met with Resident #26 to update his food preferences. She added Resident #26 requested larger portions at each meal and had discussed his request with the DM. The RD could not recall if she indicated Resident #26's request for larger portions in her dietary note but stated at the very least she would have expected for larger portions to have been implemented for Resident #26 when she gave the food preference list to the DM. During an interview on 02/13/19 at 4:45 PM the Administrator stated it was his expectation for residents' dietary preferences to be honored and larger portions implemented when requested.	F 803	can modify this plan to ensure the facility remains in compliance. Title of the person responsible for implementing the plan: " The Dietary Manager and Administrator are responsible for implementing the plan	
F 807 SS=E	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident	F 807		3/14/19

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F 807	Continued From page 25 hydration. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to provide drinks consistent with the resident's preference for 1 of 1 resident reviewed for preferences (Resident #44). The findings included: Resident #44 was admitted to the facility on 11/25/14 with diagnoses including heart failure, hypertension, non-Alzheimer's dementia, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 1/12/19 revealed that Resident #44 was severely cognitively impaired. An interview with Resident #44 on 2/13/19 at 10:03 AM revealed the facility wrote a letter which said they would no longer provide her buttermilk but no one at the facility had talked to her about this and she did not know why she stopped getting her buttermilk. She further stated that buttermilk was her preference and that she used to get it. An interview with the Dietary Manager on 2/12/19 at 3:35 PM revealed the facility did not order buttermilk any more. She stated they used to provide buttermilk but no longer provide it to residents. She further stated it was on her order sheet and she can get it but due to the low census at the facility her dietary budget had been trimmed down. She further stated she was aware the facility management had sent a letter to residents and families about no longer providing special requests for nourishments but she had	F 807	F807 Drinks Available to Meet Needs/Preferences /Hydration CFR(s) 1. The plan for correcting the specific deficiency: " Resident #44 has been provided with requested buttermilk in portions of one glass per meal with an effective date of 2/14/19. " Facility will honor preferences for such beverages in accordance with CFR in reasonable portions regardless of Facility budget or formulary. 2. How the facility will identify other residents having the potential to be affected: " On 2/14/19 a 100% audit of all resident food preferences was conducted to ensure accuracy of resident meal tickets. " On 2/14/19 facility purchased items for residents with specific preferences that were not being met by current formulary/menu. These items were added to meal tickets to be served at meal times. 3. Measures put into place: " Resident food committee meets monthly and will review menu/food preferences. " Resident council meets monthly and will review menu/food preferences. " Dietary manager to review meal tickets weekly to safeguard against errors and improve patient centered care.	

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F 807	Continued From page 26 not seen or endorsed this letter. A review of the letter signed by the facility Administrator dated 1/10/19 read in part "We cannot provide special requests. If you wish to purchase specialty items such as buttermilk or certain types of bread not in our formulary you can still purchase these items with your monthly resident funds account." An interview with the Administrator on 2/13/19 at 4:53 PM revealed his expectation was the facility should meet the needs of the residents within reason. He stated he did have a discussion with Resident #44 about food preferences and she didn't care for the facility food and wanted to have more buttermilk than the facility found to be reasonable but he did not discuss buttermilk specifically with Resident #44 nor did he discuss a compromise about the amount of buttermilk she could be provided daily. The Administrator stated he was directed to send out the letter by the corporate office stating resident requests could not be excessive. He further revealed buttermilk 2-3 times per day instead of regular milk was a reasonable resident request and that buttermilk had already been purchased for the resident.	F 807	" Documentation and communication to be made by staff as appropriate to the dietary manager if a resident preference needs to be updated. Updated preferences will be given to Dietary manager. " Weekly audit form to be given to Administrator showing changes/corrections made to dietary preferences for 4 weeks. " Dietary Manager will conduct random audit on 4 residents monthly for 2 months to ensure that preferences are provided. " Checklist added to Weights Meeting to review any preference changes. " Preferences of residents to be taken quarterly by Dietary Manager and updated as necessary. Monitoring the plan: " Dietary Manager 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. Title of the person responsible for implementing the plan: " The Dietary Manager and Administrator are responsible for implementing the plan	