STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 02/26/2021

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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E 000	Initial Comments An unannounced Recertification, complaint and follow-up survey was conducted 2/22/21 through 2/26/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #EO1E11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification, complaint and follow-up survey was conducted 2/22/21 through 2/26/21. 1 of 27 complaint allegations was substantiated. Event ID EO1E11.	F 000		
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 interview the facility failed to code a therapeutic diet on the Minimum Data Set (MDS) assessment for 1 of 6 residents reviewed for nutrition (Resident #63). Findings Included: Resident #63 was admitted to the facility on 12/17/12 and diagnose included diabetes, heart failure, atrial fibrillation, and chronic pain. Review of the physician ' s orders for Resident #63 revealed an order for a low concentrated sweet (LCS) diet dated 4/10/18. An annual Minimum Data Set (MDS) dated 1/6/21 for Resident #63 did not identify the resident received a therapeutic diet during the look-back	F 641	F-641 Resident # 63 assessment for a therapeutic diet was transmitted to the Quality Information and Evaluation (QIES) on 2/26/2021 by the Minimum Data Set Nurse. On 2/26/2021 an in-service was given to the Minimum Data Set Nurse by the Administrator to ensure that all residents on a therapeutic diet are coded accurately before transmitting per RAI manual K0150D. All new hired Minimum Data Set Nurses will be in serviced during orientation. An in service was conducted by the Administrator to the Next Level Regional	3/13/21

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

Electronically Signed | 03/16/2021

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F 641	Continued From page 1 period. A phone interview on 2/26/21 at 10:00 am with the MDS Nurse revealed Resident #63 ' s annual MDS dated 1/6/21 had been coded incorrectly. She stated the resident was on a diabetic diet during the look-back period for that MDS and should have been coded for a therapeutic diet. The MDS Nurse added she would need to do a modification for this MDS. A phone interview on 2/26/21 at 12:15 pm with the Administrator revealed she expected the MDS to be coded accurately to reflect the resident ' s health conditions.	F 641	Culinary Service Director on accurate coding of section K0510D per RAI manual on 3/13/2021. A 100% audit was performed by the Director of Nursing on 3/13/2021 for all residents on therapeutic diets. The last completed assessments for all in house residents were reviewed and adjusted as required. Monitoring of resident on therapeutic diets to ensure accurate coding of section K will be weekly times 12 weeks by the Director of Nursing or designee. Any discrepancy will be immediately reported to the Administrator for intervention. The Administrator will report findings to the QAPI intradisciplinary team monthly times 3 months. The team consist of the Director of Nursing, Medical Director, Social Worker, Admission Coordinator, Administrator, Minimum Data Set Nurse, Maintenance Director, Central Supply Supervisor, Dietary Manager, Environmental Supervisor, Rehabilitation Manager and Business Office Manager. Review of the plan of correction to continue, modify or alter will be discussed. The Director of Nursing is responsible for this plan of correction. The alleged date of compliance is 3/13/2021	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		3/1/21

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F 656	Continued From page 2 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). (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.	F 656		

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F 656	Continued From page 3 (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 record review and staff interview the facility failed to develop a plan of care for an indwelling urinary catheter. This was evident for 1 of 1 resident that was reviewed for urinary catheters (Resident #26). Findings Included: Resident #26 was admitted to the facility on 12/10/20 and diagnoses included stage 4 pressure ulcer to sacrum, heart failure and Alzheimer ' s Disease. Review of the admission nursing assessment dated 12/10/20 for Resident #26 identified she had an indwelling urinary catheter. An admission Minimum Data Set (MDS) dated 12/16/20 for Resident #26 identified the resident had an indwelling urinary catheter and was totally dependent with 2-person staff assist for toilet use. Review of the Care Area Assessment Summary identified urinary incontinence and indwelling urinary catheter had triggered and would proceed to care plan. Review of the comprehensive care plan dated 12/20/20 for Resident #26 did not include a care plan for her indwelling urinary catheter. A phone interview on 2/26/21 at 10:00 am with the MDS Nurse revealed Resident #26 had been coded for an indwelling urinary catheter on her	F 656	F-656 Resident # 656 care plan was updated to reflect the indwelling urinary catheter by the Minimum Data Set Nurse on 2/26/2021. A 100% audit was performed by the facility administrator on 3/1/2021 for all residents to ensure care plans have been developed for residents with an indwelling urinary catheter. On 2/26/2021 an in-service was given to the Minimum Data Set Nurse by the Administrator to ensure that all residents with an indwelling urinary catheter had a developed care plan. All new hired Minimum Data Set Nurses will receive in servicing during orientation for development of a care plan for an indwelling catheter . Monitoring of resident for care plan to be development for indwelling urinary catheter weekly times 12 weeks by the Director of Nursing. Any discrepancy will be immediately reported to the Administrator for intervention. The Administrator will report findings to the QAPI intradisciplinary team monthly times 3 months.	

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F 656	Continued From page 4 admission MDS dated 12/16/20 and the care area assessment summary had stated to proceed with a care plan for the indwelling urinary catheter. The MDS Nurse stated she did not know why a care plan had not been developed, but there should have been. A phone interview on 2/26/21 at 12:15 pm with the Administrator revealed a care plan should have been developed for Resident #26 ' s indwelling urinary catheter.	F 656	The first QAPI meeting was March 4,2021. The team consist of the Director of Nursing, Medical Director, Social Worker, Admission Coordinator, Administrator, Maintenance Director, Central Supply Supervisor, Dietary Manager, Environmental Supervisor, Rehabilitation Manager and Business Office Manager. The intradisciplinary team will discuss the plan of correction for continuation, modification or need to alter. The Director of Nursing is responsible for this plan of correction. The alleged date of compliance is 3/1/2021	
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 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	F 690		3/2/21

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F 690	Continued From page 5 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 and staff interview the facility failed to obtain a physician ' s order for an indwelling urinary catheter. This was evident for 1 of 1 resident reviewed for urinary catheters (Resident #26). Findings Included: Resident #26 was admitted to the facility on 12/10/20 and diagnoses included stage 4 pressure ulcer to sacrum, heart failure and Alzheimer ' s Disease. Review of the admission nursing assessment dated 12/10/20 for Resident #26 identified she had an indwelling urinary catheter. An admission Minimum Data Set (MDS) dated 12/16/20 for Resident #26 identified the resident had an indwelling urinary catheter and was totally dependent with 2-person staff assist for toilet use. Review of the physician ' s orders for Resident	F 690	F-690 Resident # 26 indwelling urinary catheter orders were transcribed in Point Click Care by the Director of Nursing on 3/1/2021. On 2/26/2021 an in-service was given to the Director of Nursing by the Administrator to ensure that all residents with urinary catheter must have physician orders in place. An in service was initiated on 2/26/2021 by the Director of Nursing for all licensed nurses to ensure that all residents with indwelling urinary catheters have physician orders to accompany catheter usage. In- servicing continues for all new hired licensed nurses as well as supplemental contracted license nurse staff. A 100% audit was performed by the	

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F 690	Continued From page 6 #26 from 12/10/20 through 2/24/21 revealed there were no orders for an indwelling urinary catheter or for catheter care. An observation of Resident #26 on 2/23/21 at 11:39 revealed the resident had an indwelling catheter. An observation of Resident #26 on 2/25/21 at 10:55 am revealed the resident ' s catheter was draining amber colored urine and no leakage was noted. An interview on 2/25/21 at 12:05 pm with Nurse #1 revealed she was not aware Resident #26 did not have a physician ' s order for her catheter. She stated she would not know if there was an order because she only focused on what was in the computer and never thought about the resident having an order for the catheter. Nurse #1 stated when the catheter had become dislodged, she just looked at the catheter to see what size it was and put a new one in; she added she did not look for a physician ' s order. Nurse #1 explained catheter orders should be obtained on admission. An interview on 2/25/21 at 12:30 pm with Nurse #3 revealed if a resident had a catheter and did not have an order, she would notify the physician and obtain an order. She stated if the resident ' s catheter became dislodged, she would not reinsert the catheter without notifying the physician and obtaining an order. A phone interview on 2/26/21 at 10:20 am with the Director of Nursing (DON) revealed she was not aware Resident #26 did not have a physician ' s order for her indwelling catheter. She stated if a	F 690	facility administrator on 3/2/2021 for all residents with an indwelling urinary catheter to ensure an order was in Point Click Care. Monitoring of resident with urinary catheters to ensure orders are in place will be weekly times 12 weeks by the Minimum Data Set Nurse. Any discrepancy will be immediately reported to the Director of Nursing for intervention. The Director of Nursing will report findings to the QAPI intradisciplinary team monthly times 3 months. The first QAPI meeting was March 4,2021. The team consist of the Director of Nursing, Medical Director, Social Worker, Admission Coordinator, Administrator, Minimum Data Set Nurse, Maintenance Director, Central Supply Supervisor, Dietary Manager, Environmental Supervisor, Rehabilitation Manager and Business Office Manager. Review of the plan of correction to continue, modify or alter was discussed . The Minimum Data Set Nurse is responsible for this plan of correction. The alleged date of compliance is 3/2/2021	

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F 690	Continued From page 7 resident had a catheter there should be a physician ' s order that included the size and what catheter care should be provided. The DON stated she wasn ' t sure why there were no physician orders for Resident #26 ' s catheter and she would notify the physician to obtain an order. A phone interview on 2/26/21 at 12:15 pm with the Administrator revealed she expected a physician ' s order would be obtained for an indwelling catheter that included how the staff should care for the catheter.	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, interview with the pharmacy Nurse Consultant and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 28 medication opportunities, resulting in a medication error rate of 14.29% for 1 of 3 residents (Resident #18) observed during medication pass. The findings included: Resident #18 was readmitted to the facility on 10/10/2019 with cumulative diagnoses which included dysphagia following traumatic head injury, epilepsy and placement of a gastrostomy tube (GT placed into the stomach for nutritional support and/or medication administration). Review of the February 2021 physician orders	F 759	F-759 Nurse #2 was in serviced by Polaris Pharmacy Nurse Consultant on 2/24/2021 on medication administration to include equivalent of cubic centimeters (cc) and millimeter (ml). On 2/24/2021 Nurse #2 received another observed medication pass by the Pharmacy Nurse Consultant. Nurse #2 was removed from the medication cart and in serviced on the policy for medication administration. Nurse #2 remained off the medication cart until successful completion of a medication administration pass with error	3/10/21

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F 759	Continued From page 8 revealed in part orders that read: · Ondansetron HCL solution 4 milligrams (mg) /5 milliliters (ml). Give 5 ml via GT 4 times a day for nausea and vomiting. · Multivitamin liquid 5 ml via GT as a supplement. · Levetiracetam Keppra solution 18 ml via GT 2 times a day for epilepsy. · Glycolax powder 17 grams via the tube 2 times a day for constipation. Review of the Medication Administration Record revealed the above medications were scheduled for a morning dose at 9:00 AM. Observation during the medication pass on 2/24/21 at 8:45 AM with Nurse #2 as she prepared medications for administration via a GT to Resident #18 was conducted. Nurse #2 was observed pouring ondansetron 7.5 ml into a medicine cup, then poured liquid multivitamin solution 7.5 ml into another medicine cup and prepared to administer via GT until the surveyor intervened. At 8:48 AM on 2/24/21 an inquiry was made about the 7.5 ml amount of ondansetron solution and liquid multivitamin prepared into the plastic medication cups. Nurse #2 remeasured 5 ml dose of the ondansetron and the liquid multivitamin solution in separate plastic medication cup. Nurse #2 was then observed pouring levetiracetam solution 15 ml into a medicine cup. She used a 6 ml syringe and measured an additional 0.3 ml of levetiracetam and ready to administer to the resident. The nurse explained an additional 3 ml was needed to make 18 ml total for the dose. The surveyor intervened. A facility Corporate Representative joined the medication pass observation and witnessed only 0.3 ml drawn into	F 759	rate less than five percent (5%). Medication observation pass with an error rate of 0% on 3/1/21 by an Administrative Registered Nurse. In servicing initiated by the Director of Nursing on 2/24/2021 on the Policy for Medication Administration. The staff receiving the in service on the policy included Licensed Nurses as well as Medication Aides. All Licensed Nurses and Medication Aides received the in service and an observed medication pass by the Director of Nursing and an Administrative Registered Nurse. All new hires will receive the in-service in orientation including all supplemental agency staff. On 3/1/2021 a competency checklist was started on every Licensed Nurse as well as every Medication Aide inclusive of supplemental agency staff. Monitoring of medication pass observations will be performed to include Licensed Nurses and Medication Aides of all scheduled staff each week. These observations will continue weekly times (X) 12 weeks and will be inclusive of all staff, including contracted supplemental agency. The Director of Nursing or designee will perform these medication pass observations. The error rate must not exceed five percent (5%) during any observation that takes place. If the error rate of a medication administration pass exceeds five percent (5%) immediate education will be provided and another medication pass will be observed. Any	

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F 759	Continued From page 9 the syringe instead of 3 ml. Interview with Nurse #2 on 2/24/21 at 9 AM in the presence of the Corporate Representative stated she needed 3 cubic centimeter (cc) not 3 ml to make a total of 18 ml. This nurse stated she always used a syringe to make sure the resident was administered a total of 18 ml of Keppra. Further inquiry with Nurse #2 revealed she had not recognized that ml and cc were the same measurements. Immediately after the interview and prompting from the Corporate Representative, Nurse #2 measured 3 ml from the 6 cc/ml syringe. Record review of the Medication Administration Record was conducted on 2/24/21 and revealed Glycolax powder 17 grams scheduled at 9:00 AM had not been noted as administered to Resident #18. Interview on 2/24/21 at 12:54 PM with Nurse #2 stated the Glycolax powder container was empty. An interview on 2/24/21 at 9:35 AM with the Corporate Representative and contracted pharmacy Nurse Consultant was conducted. The pharmacy nurse consultant stated she often comes to the facility and conducts observation of medication administration passes with Certified Medication Aides and nurses but had not conducted one with Nurse #2 recently. An interview on 2/24/21 at 10:48 AM with the Director of Nurses indicated she expected her staff to administer accurate doses of medications as ordered. The facility had made efforts to conduct medication pass observations with the medication givers and believed Nurse #2 was part of the observation. There was no response regarding the Nurse #2 lack of understanding that	F 759	error rate that exceeds 5% will be reported to the Administrator. All new hires and supplemental staff will receive an initial medication pass observation with an error rate of less than five percent (5%). The Director of Nursing will report findings to the QAPI intradisciplinary team monthly times 3 months. The first QAPI meeting was March 4, 2021. The team consists of the Director of Nursing, Medical Director, Social Worker, Admission Coordinator, Administrator, Maintenance Director, Central Supply Supervisor, Dietary Manager, Environmental Supervisor, Rehabilitation Manager, and Business Office Manager. The plan of correction will be discussed for continuation or modification by the intradisciplinary team. The Director of Nursing is responsible for this plan of correction. The alleged date of compliance is 3/10/21.	

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F 759	Continued From page 10 cc and ml were the same.	F 759		