PRINTED: 05/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345133	B. WING _			1	0 7/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	****
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F 000	INITIAL COMMENTS		F(000			
	An unannounced complaint investigation was conducted from 05/06/21 through 05/07/21. There were 34 allegations investigated and they were all unsubstantiated. Event ID# KOT411.						
F 641 SS=D	1 Accuracy of Assessments		F	341			5/12/21
	resident's status. This REQUIREMENT by: Based on record revifacility failed to accura Data Set assessment Resident #5 received evident for 2 of 2 resident for 2 of 2 resident #7 was at 09/29/20 with diagnost renal disease which review of Resident	t accurately reflect the is not met as evidenced ews and staff interviews the ately code the Minimum s to reflect Resident #7 and dialysis therapy. This was dents reviewed for dialysis.			F641 Accuracy of Assessments 1. A root cause analysis was conduct on 5/7/21 and completed on 5/11/21 to identify the root cause of the two inaccurate Minimum Data Set assessments and to ensure all resident receiving dialysis had accurate coding including resident #7 and all other curroresidents receiving dialysis. 2 out of 2 of the incorrect Minimum Data Set assessments were corrected by the RNMDS Coordinator on 5/7/2021. The root cause analysis and AD HOC QAPI meeting was led by Administrator with	ts ent of	
	hemodialysis three da Wednesday and Frida A review of Resident Minimum Data Set (M 10/05/20 revealed no A review of Resident	ays a week, Monday, ay. #7's significant change IDS) assessment dated dialysis was coded.			input from Corporate nurse consultant, Director of Nursing, RN MDS Coordina Assistant Director of Nursing, Unit Manager #1 and #2, Wound care nurse Activity Director, Social Services Direct Therapy Director, and Dietary manager The results of the root cause analysis were reviewed by QAPI on 5/10/2021 a incorporated in the plan of correction. 2. All residents have the potential to affected, therefore 100% of current	tor, e, tor, r.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

05/12/2021

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F 641	Continued From page	e 1	F 6	641			
F 641	On 05/07/21 at 4:00 F conducted with the M who confirmed she co MDS assessments fo explained it was an owould submit correctiassessments. An interview was con Nursing (DON) on 05 stated that the MDS president and she expeaccurately. An interview was con Administrator at 5:20 Administrator stated Minimum Data Set as completed. 2. Resident #5 was an 11/18/20 with diagnos renal disease that reconducted a physician read: hemodialysis the Monday, Wednesday A review of Resident (MDS) assessment disease was no dialysis coded by MDS Nurse #2. An attempt to speak to no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to the conducted was no 05/07/21 at 2:18 Positive MDS assessment to	PM an interview was DS Coordinator (MDSC) ompleted the two inaccurate in Resident #7. The MDSC eversite on her part and ons for the two inaccurate ducted with the Director of 1/07/21 at 4:33 PM. The DON oriented a picture of the exted them to be coded ducted with the PM on 05/07/21. The ner expectation was that the esessments were accurately dmitted to the facility on ses that included end stage quired hemodialysis. #5's medical record order dated 11/18/20 that ree days a week on and Friday. #5's Minimum Data Set ated 11/24/20 revealed there d. The MDS was completed of MDS Nurse #2 was made PM without success.	F6		resident assessments were reviewed a audited for accuracy by Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and Unit Manager # and #2. 3. The RN MDS Coordinator and all icensed nurse education on assessment accuracy was initiated on 5/7/2021 and completed on 05/11/2021 by Assistant Director of Nursing and Director of Nursing. Any inaccuracy discovered with the immediately addressed and correctory Director of nursing or Assistant director for nursing to ensure ongoing regulatory compliance. 4. Assessment audits were initiated of 05/07/2021 and will be completed 4x weekly for 1 month, 1x weekly for 3 months during daily clinical meeting to ensure MDS admission assessment accuracy. Audits will be completed by Director of Nursing, Assistant Director Nursing, and RN MDS Coordinator Monday through Sunday as required. Compliance date of 05/12/2021	RN 1 ent d ed etor y	
	by MDS Nurse #2. An attempt to speak ton 05/07/21 at 2:18 P An interview was con	o MDS Nurse #2 was made					

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F 655 SS=D	nurses who completed The MDSC continued of who completed Reassessment should be assessment should be The MDSC stated that MDS's remotely and was able to gather the perform the required MDS assessment. An interview was concluded that the MDS assessment and she expaction and she expanding an interview of the MDS resident and she expaction and she expaction and she expanding an interview of the MDS resident and she expanding an interview of the MDS resident and she expanding an interview of the MDS resident and she expanding an interview of the MDS resident and she expanding she expanding the she expa	led she was one of two MDS and the MDS assessments. In the MDS assessments are determined to explain that regardless asident #5's MDS, the legan accurate assessment. In the MDS Nurse #2 completed could not speak to how she legan eneeded information or interviews to complete the legan ducted with the Director of 6/07/21 at 4:33 PM. The DON painted a picture of the legan deceted them to be coded with the Administrator on she stated her expectation in Data Sets be accurately in Data Sets be accurately as a care plan for each resident and standards of quality care. In the Administrator of the resident all standards of quality care and mustain 48 hours of a resident with the Administrator on the care for a resident and the care information of the care for a resident and the care information and the care for a resident and the care for		641			5/12/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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F 655	(B) Physician orders (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomm §483.21(a)(2) The facomprehensive care care plan if the comprehensive care care plan if the comprehensive. (ii) Is developed with admission. (ii) Meets the require (b) of this section (e) this section). §483.21(a)(3) The face free finited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the on behalf of the facili (iv) Any updated info of the comprehensive.	d on admission orders. an endation, if applicable. cility may develop a plan in place of the baseline orehensive care planin 48 hours of the resident's ements set forth in paragraph (cepting paragraph (b)(2)(i) of eacility must provide the oresentative with a summary plan that includes but is not of the resident. The resident is resident and described the facility and personnel acting ity. The remaining the plant is not of the details the care plan, as necessary.	F	S55				
	by: Based on record rev facility failed to deve the area of dialysis fe #5) reviewed for dial baseline care plan fo			F655 Baseline Care Plan 1. A root cause analysis was on 5/7/2021 and completed on to identify the root cause of the inability to implement a baselin for each resident. As identified, #5 and resident #10 did not have baseline care plan. 2 out of 2 residentified are not current and have	05/11/2021 facility⊡s e care plan resident ve a esidents			

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		345133	B. WING			1	07/2021
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					DEFICIENCY)		
F 655	Continued From page	e 4	F	655	disabassad As AD LIGG OAD section		
	1 Posidont #5 was a	dmitted to the facility on			discharged. An AD HOC QAPI meeting was completed on 5/7/2021 and was le		
		ses that included end stage			by Administrator with input from Corpor		
	renal disease.	ses that included end stage			nurse consultant, Director of Nursing, F		
	Teriai discase.				MDS Coordinator, Assistant Director of		
	Review of a physiciar	n order dated 11/18/20 read,			Nursing, Unit Manager #1 and #2, Wou		
	outpatient hemodialy				care nurse, Activity Director, Social		
	Wednesday, and Frid	•			Services Director, Rehabilitation Direct	or,	
	,	•			and Dietary manager. The results of the		
	Review of Resident #	5's medical record revealed			root cause analysis were reviewed by		
	no baseline care had	been developed for the care			QAPI on 05/10/2021 and incorporated	in	
	and treatment require	ed for dialysis.			the plan of correction. 2. All residents have the potential to	oe	
	Review of a compreh	ensive Minimum Data Set			affected, therefore 100% of the current		
	(MDS) dated 11/24/20	0 revealed the Resident #5			resident⊡s baseline care plans were		
		for daily decision making			completed and audited for completion		
	-	e to total assistance with			accuracy by Director of Nursing, Assist		
		g. Dialysis was not checked			Director of Nursing, RN MDS Coordina	tor,	
	on this MDS assessm	nent.			and Unit Manager #1 and #2 to ensure		
	D: - + #5	h			ongoing regulatory compliance.		
	12/04/20.	charged from the facility on			All licensed nurses (including RN Assistant Director of		
	12/04/20.				MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wou		
	An interview was con	ducted with Unit Manager			nurse), Dietary manager, Social Servic		
		5/06/21 at 4:41 PM. Both			director, Therapy director, and Activity	C3	
		hedule and confirmed that			director were educated on the regulato	rv	
		#2 worked the day Resident			compliance for baseline care plans. Th	-	
	#5 admitted to the fac				baseline care plan education began on		
	completed the baseling	ne care plan. The UMs			5/07/2021 and completed 05/11/2021 a	and	
	stated that there was	an admission checklist that			was completed by Director of Nursing,		
		sident and it listed each			Regional MDS consultant, and Regiona	al	
		to be completed by either			Nurse consultant. All new hires will be		
		of the UMs and baseline			educated on completing baseline care		
	-	on the checklist. UM #1			plans upon hire.		
		the hall nurse would greet			4. Baseline care plan audits were		
	_	n settled in their room and			initiated on 5/07/2021 and will be		
	then complete the ad				completed 4x weekly for 1 month, 1x	J	
		e care plan, obtain vital			weekly for 3 months during daily clinica		
	aigna, and enter a ge	neral nurse's note in the			meeting to ensure regulatory compliand	- -	

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F 655	Continued From page	÷ 5	F	655			
	medical record and co care plan had been d An interview was con	2 reviewed Resident #5's onfirmed that no baseline eveloped for Resident #5. ducted with Nurse #1 on Nurse #1 confirmed that			regarding baseline care plans. Audits was be completed by Director of Nursing, Assistant Director of Nursing, and RN MDS Coordinator Monday through Sunday as required.	vill	
	she worked the unit we but could not recall R stated that during the admitted the facility we admissions and the a scattered" which mean best you could do." No initiating base line can know how to properly added that "sometime the assessments." No was working the next finish any of the admit complete. Nurse #1 segenerally relived her of pick up with the admit complete what had not that if the baseline can they would be docum medical record. Nurse not recall Resident #5 completing his base line.	dmission process "was nt "basically you did the urse #1 confirmed that re plan allowed the staff to care for the resident. She es I did not get to do any of urse #1 indicated that if she day, she would again try to ession process that was not tated that Nurse #2 on third shift, and she would ession process and try to ot yet been done. She added re plan were completed, ented in the electronic e #1 stated that she could			Compliance date of 5/12/2021		
	05/06/21 at 5:24 PM. she worked the unit w but could not recall th that sometimes she g admissions or the ass nurses did not get arc	ducted with Nurse #2 on Nurse #2 confirmed that /here Resident #5 resided e resident at all. She stated					

I '		IDENTIFICATION NI IMBED		TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED		
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F 655	the admission proceselse had already con arrived for work. Nurherself and Nurse #1 had a base line care electronic medical rein the electronic medical rein the electronic medical rein the baseline care plate. An interview was con Director of Nursing (IAM. The former DON process even in Novhad always been. The checklist that include care plans. She state responsible for compassessment and base were not busy, they is She added that the bimportant document of the new resident ube developed. The Don the checklist were through 2 additional including baseline cate former DON could not Resident #5's baselin completed but stated document in his election of the could be developed. An interview was con 05/07/21 at 4:33 PM had only been at the	as but generally someone inpleted them by the she se #2 stated that between Resident #5 should have plan documented in the cord. She added if it was not lical record for some reason ans were not completed. Inducted with the former DON) on 05/07/21 at 11:27 In stated that the admission ember 2020 was the same it there was an admission and the initiation of base line and that nursing was poleting the admission eline care plans. If the UMs could assist with the process. It is a plan to a plan could approve the full care plan could approve the full care plan could approve to ensure all items are plans were done. The pot recall specifically if	F	555				
	not recall how soon to DON stated that she	admissions, but she should they should be done. The was not sure who was pleting the baseline care plan						

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F 655	DON stated she expose initiated for all new someone with dialyst specific things that not a common with dialyst specific dialyst and a common with dialyst specific dialyst	Il very new to the facility. The ected a baseline care plan to w admissions especially is since there was very eeded to be monitored. In order dated 11/24/20 read, a nasal canula. It daily schedule for 11/24/20 #3 was working the unit resided. If 10's medical revealed no ad been developed to ditreatment of oxygen. In Data Set (MDS) dated	F 6	55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 655	stated that generally the resident, get the then complete the baseli signs, and enter a gmedical record. UM medical record and care plan had been An interview was concert of Nursing AM. The former DO process even in Nowhad always been. To checklist that including care plans. She state responsible for compassessment and base were not busy, they process. She added was an important do the care of the new could be developed items on the checklist through 2 additional including baseline composition of the composition of the care of the new could be developed items on the checklist through 2 additional including baseline composition of the composition of t	y the hall nurse would greet em settled in their room and admission assessment, ne care plan, obtain vital general nurse's note in the #2 reviewed Resident #10's confirmed that no baseline developed for Resident #10. Inducted with the former (DON) on 05/07/21 at 11:27 N stated that the admission wember 2020 was the same it there was an admission ed the initiation of base line ted that nursing was pleting the admission seline care plans. If the UMs could assist as well with the did that the baseline care plan coument because it directed resident until the full care plan. The DON stated once all the ist were completed it would go a reviews to ensure all items hare plans were done. The not recall specifically if the plans were done and the interest of the tit fithey were it would be extronic medical record. It to Nurse #3 was made on M and was unsuccessful.	F 65			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUII		PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
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F 684 SS=D	not recall how soon the DON stated that she responsible for complete because she was still DON again stated she plan to be initiated for especially someone volume of Care CFR(s): 483.25 § 483.25 Quality of care is a functional applies to all treatments facility residents. Bas assessment of a residents	ney should be done. The was not sure who was eting the baseline care plan very new to the facility. The expected a baseline care all new admissions with that required oxygen. The expected a baseline care all new admissions with that required oxygen. The expected a baseline care all new admissions with that required oxygen.	F 68	55		5/12/21	
	practice, the compreh care plan, and the res This REQUIREMENT by: Based on record revifacility failed to compl assessment that incluassessment for 2 of 1 and Resident #10) ret The findings included 1. Resident #5 was an 11/18/20 with diagnos renal disease. Review of Resident # no admission assessing Resident #5's stay in Resident #5's medical	ensive person-centered sidents' choices. is not met as evidenced ew and staff interview the ete an initial admission ded a baseline skin 0 residents (Resident #5 viewed for pressure ulcers.		F684 Quality of Care 1. A root cause analysis was cond on 5/7/2021 and completed on 05/1 to identify the root cause of the facili error by not completing an initial skir assessment on resident #5 and resident #10. 2 out of 2 residents identified a current and have discharged. An ADQAPI meeting was completed on 5/3 and was led by Administrator with in from Corporate nurse consultant, Diof Nursing, RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Wound care nu Activity Director, Social Services Dir Rehabilitation Director, and Dietary manager. The results of the root cause	1/2021 ty n dent re not 0 HOC 7/2021 put rector		

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F 684	Continued From page	e 10	F	684			
F 684	the facility. Review of the facility revealed that Nurse # where Resident #5 re PM and Nurse #2 was PM to 7:00 AM. Review of a compreh (MDS) dated 11/24/20 was cognitively intact and required extensive activities of daily living that the facility did no was at risk for skin brown as at risk for skin brown at risk for	daily schedule for 11/18/20 21 was working the unit sided from 7:00 AM to 7:00 s working that unit from 7:00 ensive Minimum Data Set Direvealed the Resident #5 for daily decision making re to total assistance with g. The MDS further indicated the assess the if Resident #5 eakdown. harged from the facility on ducted with Unit Manager 5/06/21 at 4:41 PM. Both hedule and confirmed that #2 worked the day Resident estility and should have sion assessments which the skin assessment. UM #1 the hall nurse would greet in settled in their room and mission and skin ital signs, and enter a sin the medical record. Um the #5's medical record and mission assessment nor skin in completed but stated that and recall Resident #5. ducted with Nurse #1 on		684	analysis were reviewed by QAPI on 05/10/2021 and incorporated in the pla correction. 2. All residents have the potential to affected, therefore 100% of the current resident admission and skin assessme were audited for completion by Directo Nursing, Assistant Director of Nursing, MDS Coordinator, and Unit Manager # and #2 to ensure ongoing regulatory compliance. 3. All licensed nurses (including RN MDS Coordinator, Assistant Director of Nursing, Unit Manager #1 and #2, Woonurse), Dietary manager, Social Service director, Therapy director, and Activity director were educated on the regulato compliance for completing the resident assessments. The resident assessment education began on 5/07/2021 and completed 05/11/2021 and was completed Director of Nursing, Regional MDS consultant, and Regional Nurse consultant. All new hires will be educated on completing admission and skin assessments upon hire. 4. Admission assessment audits were initiated on 5/07/2021 and will be completed 4x weekly for 1 month, 1x weekly for 3 months during daily clinical meeting to ensure regulatory compliance regarding resident assessment completion. Audits will be completed by Director of Nursing, Assistant Director Nursing, and RN MDS Coordinator Monday through Sunday as required.	nts r of RN 1 : und es ry ut eted e	
	05/06/21 at 5:01 PM.	Nurse #1 confirmed that here Resident #5 resided			Compliance date of 5/12/2021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		, ا	C	
		345133	B. WING				07/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	***************************************	
				1	000 COLLEGE STREET			
ACCORD	IUS HEALTH AT WILKES	SBORO		v	VILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 684	but could not recall is stated that the admis admission assessment along wassessments. She are Resident #5 was admultiple admissions "was scattered" which the best you could do "sometimes I did not assessments." Nurse working the next day any of the admission assessment that had #1 stated that Nurse third shift, and she wadmission process a admission assessment that if the completed, they would electronic medical recall completing his skin assessment but medical record then complete them." An interview was con 05/06/21 at 5:24 PM she worked the unit but could not recall the stated that the admission assessments that the admission assessments that the complete admission assessments that the around to completing assessments are also as a session assessments that the around to completing assessments that the around to completing assessments are also as a session as a	Resident #5 at all. Nurse #1 ssion process included the ent and a head to toe skin with several other idded that during the time mitted the facility was taking and the admission process th meant "basically you did o." Nurse #1 stated that it get to do any of the se #1 indicated that if she was y, she would again try to finish in assessment and skin d not been complete. Nurse if #2 generally relieved her on would pick up with the and try to complete the ent and skin assessment.	F	684				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345133	B. WING _			C 05/07/2021	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT WILKESBORO				STREET ADDRESS, CITY, STATE, ZIP CO 1000 COLLEGE STREET WILKESBORO, NC 28697	DDE	33/37/2321	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE COMPLE EFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPLE DAT DAT		
F 684	Continued From page 12		F 6	684			
	included a head to to completed on admiss electronic medical re in the electronic med the admission assess assessment were no An interview was cor	sion and documented in the cord. She added if it was not ical record for some reason sment and subsequent skin					
	AM. She stated that a completing the admistoe skin assessment, several other assess busy, they could also process. The former could not complete the then the next shift shift them as well. The for specifically if Resider assessment and skin	nursing was responsible for sion assessment, head to fall risk assessment and ments. If the UMs were not assist as well with the DON stated that if one shift ne admission assessments ould be working to complete mer DON could not recall					
	An interview was cor 05/07/21 at 4:33 PM. had only been at the stated that she expectomplete the requires skin assessment improved at the facility medical record. 2. Resident #10 was 11/24/20 with diagno polyarthritis, hyperter	Inducted with the DON on The DON stated that she facility for a few weeks. She cted the nursing staff to d admission assessment and mediately after the resident and document them in the admitted to the facility on					
	and others. Review of Resident #	∮10's medical record					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345133	B. WING _			C 05/07/2021	
	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697			00/01/2021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIA	DATE	
F 684	facility. Further review record revealed no so completed upon administration of the facility indicated that Nurse where Resident #10 Review of the Minimum 11/30/20 indicted that cognitively intact and assistance with activity further revealed that pressure ulcer. Resident #10 discharing 11/30/20. An interview was correctly further revealed that generally the resident, get therefore the completed the assessment, obtain vigeneral nurse's note #1 and UM #2 stated assessment and subwere to be done upon the resident's medical recompleted. An interview was correctly for the medical recompleted. An interview was correctly for the medical recompleted. An interview was correctly for the medical recompleted.	on assessment was sident #10's stay in the w of Resident #10's medical kin assessment was sission to the facility. Is daily schedule for 11/24/21 #3 was working the unit resided. In Data Set (MDS) dated the Resident #10 was sident #10 was sident #10 was at risk for required extensive sides of daily living. The MDS Resident #10 was at risk for reged from the facility on settled in their room and admission and skin wital signs, and enter a sin the medical record. UM that the admission sequent skin assessment in admission and entered into all record and if the they were	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345133	B. WING _			C 05/07/2021	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT WILKESBORO				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	(X5) COMPLETION DATE			
F 684	busy, they could also process. The former I could not complete the then the next shift should them as well. The formal specifically if Resident assessment and skin but stated that if it was the electronic medical. An attempt to speak to 05/07/21 at 3:17 PM at a ninterview was conducted to 05/07/21 at 4:33 PM. had only been at the stated that she expect complete the required skin assessment immediate.	nents. If the UMs were not assist as well with the DON stated that if one shift e admission assessments ould be working to complete mer DON could not recall t #10's admission assessment was completed it would be document in	F	584			