STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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E 000	Initial Comments An unannounced COVID-19 Focused Survey and complaint investigation was conducted from 8/12/2021-9/3/2021. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# MR1W11	E 000		
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/12/21 through 9/3/21. Event ID# MR1W11. 5 of the 15 complaint allegations were substantiated resulting in deficiencies. (amended 9/16/21) Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/9/21 and was removed on 8/14/21 with validation of of the facility's credible allegation. An extended survey was conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		10/8/21

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

Electronically Signed | 09/24/2021

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F 580	Continued From page 1	F 580		

results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews the facility failed to provide notification of change in condition for 2 of 3 residents, Resident #1 and Resident #9, reviewed for notification. The facility did not notify the Physician or the Responsible Party that Resident #1 had ingested an unidentified object and failed to notify the Responsible Party that Resident #9 tested positive for COVID-19 and was transferred to the COVID-19 quarantine unit. Findings included: 1. Resident #1 admitted to the facility on 4/1/2020 with diagnoses of dementia and psychosis. The most recent Minimum Data Set (MDS) assessment, a quarterly assessment, dated 7/30/2021 revealed Resident #1 was severely cognitively impaired. A Progress Note dated 8/12/2021 by the Nurse Practitioner revealed staff reported Resident #1 had ingested a rodent and had vomited on 8/9/2021. The Progress Note further revealed the Nurse Practitioner had called Poison Control regarding the possible rodent ingestion. During an interview with the Administrator on 8/12/2021 at 6:39 pm she stated Nurse Aide #1 had reported Resident #1 had spit up fur and grizzle that may have been a mouse's tail on 8/9/2021. The Administrator stated the Physician was made aware of the incident on 8/10/2021	F 580	1. Resident #1 responsible party was notified by the Director of Nursing on 8/12/21 that the resident had ingested an unidentified object on 8/9/21 and the Nurse Practitioner was notified on 8/12/21. Resident #9 tested positive for COVID on 1/12/21 and transferred to the COVID unit. Resident #9's family has been notified as of 9/25/2021 by the Administrator. 2. An audit will be completed of the current residents by the Director of Nursing/designee to ensure that physician and the resident responsible parties have been notified of changes in condition for the last 30 days to include ingestion of unidentified objects and notification of COVID positive residents by 9/30/21. 3. The licensed nursing staff will be reeducated on ensuring the physician and the responsible parties are notified for resident changes in condition by the Director of Nursing or designee. The progress notes and risk incidents will be reviewed by the Director of Nursing/designee during morning clinical meeting Monday through Friday to ensure that resident responsible parties and the physicians are being notified for changes in condition using the morning stand-up sheet to monitor. Administrator or	

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F 580	Continued From page 3 when he came to the facility to see residents. An interview was conducted with the Director of Nursing (DON) on 8/12/2021 at 7:15 pm and she stated on 8/9/2021 she saw Resident #1 in the hallway with a 2-inch-long, dark colored string hanging from his mouth. She stated before she could stop him, he swallowed it. She stated she inspected his mouth but there was nothing in his mouth. The Director of Nursing stated she reported the incident to the Physician when he came to the facility the next morning, 8/10/2021. On 8/13/2021 at 9:58 am Nurse #1 was interviewed, and she stated she cared for Resident #1 on 8/9/2021 when he ingested an unidentified object on 8/9/2021. She stated she did not report the incident to the physician because she thought the DON was going to report it to the physician. During an interview with the Nurse Practitioner on 8/13/2021 at 12:00 pm she stated she was told by the Director of Nursing on 8/12/2021 that Resident #1 may have ingested a mouse on Monday, 8/9/2021. She stated she was told by the DON when she came to the facility to see residents, but she had not been called in to see Resident #1. The Nurse Practitioner stated she called Poison Control because she was concerned about the possibility the mouse could have been poisoned and the types of infections a mouse may carry. She stated she was told by Poison Control Resident #1 should be monitored for fever and bloody stools and diarrhea. The Nurse Practitioner stated she had examined Resident #1 on 8/12/2021 for any bite marks on his face and in his mouth.	F 580	designee will review the previous 30 days of nursing notes to ensure notification has been done. This review will be completed by 9/30/21. Administrator has reeducated staff in regards to notifying all families of any positive COVID 19 test results. Administrator will review resident roster at time of any positive test results of COVID 19 to ensure all responsible parties or guardians have been notified of any positive case ongoing. 4. The results of the reviews of the progress notes/risk incident will be discussed in the monthly QAPI committee meeting for at least three months. The interdisciplinary team will recommend revisions to the plan as indicated to maintain substantial compliance. 5. Date of compliance 10/8/21	

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A follow-up interview was conducted with the DON on 8/13/2021 at 3:26 pm. She stated she had reported to the Family Member on 8/12/2021 that Resident #1 had ingested an unidentified object on 8/9/2021.

On 8/17/2021 at 7:58 pm the Administrator was interviewed and stated the Director of Nursing should have notified the physician Resident #1 may have swallowed an unidentified object when the incident happened on 8/9/2021.

2. Resident #9 admitted to the facility on 1/10/2020 and his diagnoses included seizure disorder and a traumatic brain injury.

The most recent Minimum Data Set assessment dated 7/17/2021 revealed Resident #9 was severely cognitively impaired.

A Nurse's Progress Note dated 1/12/2021 at 1:35 pm written by Nurse #9 stated Resident #9 tested positive for COVID-19 and was transferred to the COVID-19 quarantine unit. The Nurse's Progress Note did not specify the Responsible Party was notified of Resident #9 testing positive for COVID-19 or his transfer to the COVID-19 quarantine unit.

During an interview with the Responsible Party on 8/25/2021 at 3:22 pm he stated he had not been notified Resident #9 had a positive COVID-19 test and was not notified Resident #9 was moved to a COVID-19 quarantine unit on 1/12/2021.

During an interview with Nurse #9 on 8/26/2021 at 10:19 am she stated she could not remember if she had notified the Responsible Party that Resident #9 had a positive COVID-19 test and

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F 580	Continued From page 5 was moved to the COVID-19 quarantine unit on 1/12/2021. Nurse #9 stated she would have put it in her note if she had notified the Responsible Party. An interview was conducted with the previous Director of Nursing on 8/27/2021 at 10:12 am and she stated Nurse #9 would have been responsible for notifying the Responsible Party that Resident #9 had tested positive for COVID-19 and was moved to the COVID-19 quarantine unit. The Administrator was interviewed on 8/27/2021 at 10:38 am and stated Nurse #9 should have notified the Responsible Party of Resident #9's positive COVID-19 test and his transfer to the COVID-19 unit. The Administrator stated she was working in the facility when Resident #9 tested positive on 1/12/2021.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		10/8/21

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F 656	Continued From page 6 (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 record review staff interviews and observations the facility failed to provide 2 of 2 residents, Resident #1, a care plan for behaviors of eating items from the trash and placing nonedible items in his mouth, and Resident #5 a care plan for physical aggression and agitation. Findings included: 1. Resident #1 admitted to the facility on 4/1/2020 with diagnoses of dementia and psychosis. A Care Plan dated 4/17/2020 stated	F 656	1. On 8/14/21 Resident #1 care plan was updated by the licensed nurse to include a care plan for behaviors of eating items from the trash and placing nonedible items in his mouth. Resident #5 was care planned for physical aggression and agitation. 2. Current resident care plans will be reviewed by the Director of Nursing/designee to ensure care plans for	

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F 656	Continued From page 7 Resident #1 had altered safety awareness. The most recent quarterly Minimum Data Set assessment dated 7/30/2021 revealed Resident #1 was severely cognitively impaired, and he did not exhibit behaviors. During an interview with the Director of Nursing on 8/12/2021 at 7:15 p she stated on 8/9/2021 she saw Resident #1 walk by in the hallway with a stryofoam food container in his hand and a 2-inch-long dark colored string hanging from his mouth. The Director of Nursing stated before she could stop Resident #1, he swallowed the string and when she inspected his mouth it was empty. The DON stated she reported the incident to the Physician the next morning, 8/10/2021. The Social Worker was interviewed on 8/13/2021 at 10:24 am and stated he was making his rounds on the 300-hall unit when he noticed Resident #1 had a Styrofoam food container in on hand and something else in his other hand. The Social Worker stated Resident #1 turned his back to him and put something in his mouth. The Social Worker stated Resident #1 turned back towards him and he had what looked like a black string hanging from his mouth that was approximately 3 to 4 inches long. The Social Worker stated he could not tell what Resident #1 put in his mouth. During an interview with Nurse Aide #5 on 8/13/2021 at 5:10 pm she stated Resident #1 had always had behaviors of getting into trash and even taking food from other resident's meal trays. During the interview which was conducted in the dining room Resident #1 was observed rummaging through the cabinets in the dining	F 656	behaviors to include eating items from the trash and placing nonedible items in mouth as well as physical aggression and agitation have been developed and implemented by 9/30/21. Administrator/Designee reeducated all staff on residents with behaviors of putting nonedible items in their mouths and eating from trash cans. all new staff and agency staff are educated prior to starting their shift. 3. The licensed nurses and social services will be reeducated by the DON/ designee to ensure that care plans for behavior to include eating item from the trash and placing nonedible items in the mouth and physical aggression and agitation have been developed and implemented by 9/30/21 Administrator/Designee will review nursing notes and risk events during morning clinical meeting report for any resident showing any aggressive behaviors or behaviors of putting items in mouth. Administrator/Designee will report behaviors to care plan team for interventions and care plan updates. Administrator/Designee will review 5 behavior care plans weekly for 4 weeks then 4 monthly for 3 months to ensure care plans are updated to show behaviors. 4. The results will be reported by the Administrator in the monthly QAPI committee meeting for at least 3 months. The interdisciplinary team will recommend	

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F 656	Continued From page 8 room. Nurse Aide #5 noticed him rummaging in the cabinets at 5:14 pm and redirected him to a chair at a dining table. An interview on 8/13/2021 at 6:53 pm with Nurse #2 revealed she had observed Resident #1 getting into the trash before 8/9/2021. She stated Resident #1 was a wanderer and will rummage in the trash if not redirected. On 8/12/2021 the Care Plan was revised to include history of eating items out of the trash and putting non-edible items into his mouth. During a follow up interview with the Director of Nursing on 8/13/2021 at 3:26 pm she stated she updated the care plan on 8/12/2021 to include Resident #1's behaviors of eating from the garbage and putting nonedible objects in his mouth after speaking with the Family Member regarding the incident on 8/9/2021 when Resident #1 swallowed an unidentified object. 2. Resident #5 was admitted to the facility on 4/22/21 and her cumulative diagnoses included stroke, dementia with behavioral disturbance, and generalized weakness. A review of Resident #5 ' s Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 8/2/21. The resident was coded as having severe cognitive loss. For Activities of Daily Living (ADLs) the resident was coded as having required supervision with the support of one person for bed mobility, transfer (such as into and out of bed to a wheelchair), walking in the room, walking in the corridor, and moving about the unit. The resident was coded for having	F 656	revisions to the plan as indicated to maintain substantial compliance. 5. Date of compliance 10/8/21	

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F 656	Continued From page 9	F 656		

displayed verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others).

Resident #5 ' s care plan, which was initiated on 5/3/21, documented the resident had a focus area for the resident having impaired cognitive function/dementia or impaired thought processes related to Alzheimer ' s, but the goals nor the interventions addressed the resident ' s behaviors. The resident ' s care plan did not have a focus area addressing her agitation and physical behavior until 8/24/21, the day after she was sent to the Emergency Room for evaluation.

Review of Resident #5 ' s medical record revealed she had 5 physical altercations with 5 different residents in the 8-day period from 8/16/21 through 8/23/21. On 8/23/21 the resident was sent out to the local Emergency Room for evaluation after the fifth physical altercation where she was observed to have pushed another resident.

During an interview conducted on 8/26/21 at 9:50 AM with the facility Social Worker (SW) he stated he had started a behaviors care plan for Resident #5 on 8/24/21, the day after she had been sent out to the ER. He explained the resident had verbal behaviors before that and had some incidents before he started the care plan for her behaviors. He said during the morning meetings, which were held Monday through Friday, they would review and discuss items which had been entered into residents ' progress notes. He said he was the person who worked on the care plans and entered in focus areas. The SW reviewed Resident #5 ' s electronic medical record and stated she had been seen by psych services on

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F 656	Continued From page 10 8/16/21, 8/18/21, had another altercation on 8/18/21, another altercation on 8/20/21, bit another resident on 8/22/21, had pushed another resident on 8/23/21, and was sent out to the ER on 8/23/21. He stated he felt the facility had addressed the resident ' s behavior and was trying to work with psych services, but he wasn ' t clinical so he could not speak on other interventions. He said the resident ' s care plan had not been updated regarding the resident ' s behaviors or documentation of the interventions related to her behaviors in the care plan from 8/16/21 through 8/23/21. An interview was conducted with the Regional Nurse Consultant on 8/26/21 at 10:30 AM. During the interview she stated the former Minimum Data Set (MDS) nurse was updating the care plans, but she was no longer at the facility. She stated resident ' s updated progress notes were reviewed in the morning meeting and the SW was helping updating the resident ' s care plans. During an interview with the administrator conducted on 8/26/21 at 10:40 AM she stated during the morning meeting they would review any changes with residents and the current person assigned to update care plans was the SW. She explained she remembered reviewing Resident #5 and the altercations she had during the morning meeting, but her care plan had not been updated regarding her agitation and physical behaviors. She said the resident ' s care plan should have been updated for behaviors during the morning meeting prior to the 8/24/21 update.	F 656		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		10/8/21

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F 686	Continued From page 11 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, family, Nurse Practitioner and staff interviews, the facility failed to assess and treat 1 of 3 residents, Resident # 2, for skin breakdown which was discovered when Resident #2 was admitted to the hospital with increased blood glucose level and a bloodstream infection. Findings included: Review of Resident #2's Medical Record revealed she was admitted to the facility on 6/5/2021 and discharged to the hospital on 7/4/2021. Resident #2 was admitted with diagnoses of diabetes and dementia. According to Resident #2's Admission Assessment dated 6/5/2021 she had bruising to the coccyx, but no open areas. The Nurse that completed Resident #2's Admission Assessment was not available for interview. Resident #2's Medical Record further revealed she did not have a skin assessment completed after her initial	F 686	1. Resident #2 was discharged from the facility on 7/4/2021. 2. Assistant Director of Nursing/Designee reviewed all current residents skin assessment completed on 9/3/21, to ensure any identified skin concerns have been addressed. 3. The licensed nurses will be reeducated by the Director of Nursing/Designee related to ensuring that residents have skin assessments are completed weekly, the physician and the responsible party are notified, and treatments are in place for any identified concerns by 9/30/21. The CNAs will be reeducated related to reporting any identified skin concerns that	

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F 686	Continued From page 12 Admission Assessment. A Care Plan dated 6/14/2021 stated Resident #2 had skin breakdown, a blistered area to her right shoulder and was at risk for further skin breakdown. The Care plan indicated the goal was for Resident #2 to have intact skin. Interventions to prevent skin breakdown included weekly skin audits and treatments to affected areas were an intervention. An Admission Minimum Data Set assessment dated 6/16/2021 revealed Resident #2 was severely cognitively impaired, required extensive assistance with bed mobility and total assistance with toileting and did not have pressure ulcers. Nurse Aide #3 was interviewed on 8/25/2021 at 1:11 pm and stated she cared for Resident #2 on 7/1/2021 and 7/2/2021. Nurse Aide #3 stated she had changed Resident #2 because she was incontinent of bowel and bladder and she did not remember Resident #2 having any skin breakdown. Nurse #1 was interviewed on 8/24/2021 at 3:57 pm and stated she had reported a blister on Resident #2's right shoulder to the Wound Nurse but had not been aware of any pressure ulcers to her sacrum or buttocks. Nurse #1 stated she had not done a skin assessment when the blistered area was found to Resident #2's right shoulder. It had been reported to her during a report from another Nurse. Nurse #1 stated she did not remember doing any skin assessments for Resident #2. Nurse #1 stated the skin assessments are done weekly and they are on the electronic Medication Administrator Record (MAR). Nurse #1 stated the MAR would	F 686	are observed during ADL care and/or showers to the licensed nurse by 9/30/21. This education will be provided to all new hires through facility orientation. Director of Nursing/designee will review 5 residents weekly from the weekly skin assessments schedule for three months to ensure skin assessments are being completed, treatments are in place as ordered, and the physician and responsible parties have been notified and are being updated on the area□s current status. Director of Nursing/Designee will review all new admissions and readmissions to ensure weekly skin assessments are scheduled during clinical meeting daily Monday thru Friday. 4. Director of Nursing will report findings in the monthly QAPI meeting for at least three months. The interdisciplinary team will recommend revisions to the plan as indicated to maintain substantial compliance. 5. Date of Compliance 10/8/21	

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automatically show that the skin assessment needed to be signed off.

During an interview with Nurse #5 on 8/25/2021 at 4:00 pm she stated she cared for Resident #2 on 7/4/2021 when she was sent to the hospital. Nurse #5 stated she did not assess Resident #2's skin and she did not remember doing a skin assessment on Resident #2 when she cared for her. Nurse #5 stated skin assessments should be done weekly and are recorded on the Medication Administration Record.

During an interview with Resident #2's Family Member on 8/25/2021 at 11:42 am she stated the facility had not notified her of the wound to Resident #2's sacrum but had called her on 7/4/2021 after 6:00 pm to tell her Resident #2 was being sent to the hospital. The Family Member stated when she arrived at the Emergency Room she was shown the wound to Resident #2's sacrum and it was as long as her hand and it was very deep with what she thought was bone showing.

A Wound Care note dated 7/5/2021 at 1:40 pm from the hospital records stated Resident #2 had an 11-centimeter by 4.2-centimeter unstageable ulcer to Resident #2's sacrum and extended to the right buttock. The note further stated the ulcer would benefit from surgical debridement.

During an interview with the Director of Nursing (DON) on 8/24/2021 at 4:36 pm she stated she did not find any skin assessments completed for Resident #2 during the time she was at the facility. The DON stated she felt the skin assessments were not added to the Medication Administration Record when Resident #2 was

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F 686	Continued From page 14 admitted, and this was the reason they had been missed. The DON stated the assessments should have been activated when Resident #2 was admitted to the facility. An interview was conducted with the Wound Care Nurse Practitioner on 8/25/2021 at 1:32 pm. The Wound Care Nurse Practitioner stated she saw Resident #2 for small blisters to her left posterior shoulder, but no other wounds were reported to her. The Wound Care Nurse Practitioner stated the Nurses should do weekly wound assessments and report any skin breakdown. The Administrator was interviewed on 8/27/2021 at 10:38 am and stated the Nursing staff should have completed a skin assessment for Resident #2 weekly from her admission to her discharge. The Administrator stated she thought the admission was not entered into the electronic system correctly and the skin assessment did not trigger for the nurses to complete them. On 9/3/2021 at 12:23 pm a follow-up interview was conducted with the Wound Care Nurse Practitioner and she stated Resident #2 would have been high risk for skin breakdown due to weakness and incontinence. The Wound Care Nurse Practitioner stated she may have had a deep tissue injury before going to the Emergency Room and depending on how long she was in the Emergency Room it could have contributed to her having an unstageable deep tissue injury.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		10/8/21

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F 689	Continued From page 15 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on hospital record review, facility record review, observation, and staff, Nurse Practitioner and Physician interviews the facility failed to provide supervision to prevent 1 of 1 residents, Resident #1, with a history of eating items from the trash, from ingesting an unidentified object. The facility also failed to assess Resident #1 for symptoms of potentially life-threatening diseases since the unidentified object was alleged to be a mouse. Immediate Jeopardy began on 8/9/2021, when Resident # 1 ingested an unidentifiable object and the facility failed to immediately and effectively respond to the situation. The Immediate Jeopardy was removed on 8/14/2021 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity of G (actual harm that is not immediate jeopardy) due to the second example. Based on hospital record review, facility record review, observation, resident, nurse practitioner, and staff interviews, the facility failed to provide supervision and effective interventions to prevent further altercations involving Resident #5 with other residents after the initial altercation on 8/16/21. As a result of one of the altercations, Resident #4 was sent to the Emergency Room	F 689	1. Resident #1 remains in the facility and care plan has been updated to reflect behaviors. Resident #1 has had no further incidents of ingesting nonedible objects. Resident #5 remains in the facility and is on 1 to 1 supervision. Resident#5 will remain 1 on 1 until behaviors show no aggression toward other residents. 2. Current residents will be reviewed by the Director of Nursing/designee to ensure safety/ supervision concerns have been addressed, care plans updated, and interventions implemented if needed by 9/30/21.Director of Nursing audited all residents with behavior concerns and updated care plan as necessary for any behaviors related to putting unknow objects in their mouth. 3. Staff will be reeducated by the Director of Nursing/ designee by 9/30/21 related to addressing resident safety concerns related putting unknown objects in their mouth, adequate resident supervision is being maintained, the physician/ responsible parties/ facility administration are being notified to ensure that safety measures and resident supervision are in place. New employees including agency staff will be educated prior to starting any shift. Staff were	

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(ER) where she received a tetanus shot and was prescribed two separate oral antibiotics, which was determined to be a level G (actual harm that is not immediate jeopardy) deficient practice. Resident #5 was placed on one-to-one supervision during the investigation.

Findings included:

1. Resident #1 admitted to the facility on 4/1/2020 and resided in a secure unit. His diagnoses included dementia and psychosis. There was not a care plan for Resident #1 ' s behavior of eating from the trash or putting non-edible items in his mouth.

The most recent quarterly Minimum Data Set (MDS) assessment dated 7/30/2021 revealed Resident #1 was severely cognitively impaired; ambulated with supervision only; and did not have any behaviors.

The Director of Nursing (DON) was interviewed on 8/12/2021 at 7:15 pm and stated she was on the unit where Resident #1 resides on the evening of 8/9/2021. She stated she exited a room and Resident #1 walked by with a styrofoam food container from the trash in his hand and a 2-inch-long dark colored string hanging from his mouth. The DON stated before she could stop Resident #1, he swallowed the string. The DON stated she inspected his mouth and there was nothing in his mouth. The DON stated she left the unit and when she returned about 20 minutes later Nurse #1 told her Resident #1 had vomited or spit up. The DON stated she did not look at what Resident #1 had spit up. The Director of Nursing stated she reported the incident to the Administrator at that time and to

reeducated as of 9/15/21 on residents with behavior of putting objects in their mouth.

Administrator/Designee will review new admissions for history of behaviors to ensure care plan are implemented to reflect behaviors for three (3) months daily in morning clinical meeting Monday thru Friday.

4. Identified safety/supervision concerns will be reviewed by the interdisciplinary team during morning clinical meeting to ensure that safety measures are in place and adequate supervision is being maintained. The results will be reviewed in the monthly QAPI meeting for at least 3 months. The interdisciplinary team will recommend revisions to the plan as indicated to maintain substantial compliance.

5. Date of compliance 10/8/21

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the Physician the next morning, 8/10/2021. The DON stated the Physician did not give orders for follow up for Resident #1.

The Social Worker was interviewed on 8/13/2021 at 10:24 am and stated he was making his rounds on the 300-hall unit when he noticed Resident #1 had a styrofoam food container in on hand and something else in his other hand. The Social Worker stated Resident #1 turned his back to him and put something in his mouth. The Social Worker stated Resident #1 turned back towards him and he had what looked like a black string hanging from his mouth that was approximately 3 to 4 inches long. The Social Worker stated he could not tell what Resident #1 put in his mouth. The Social Worker stated he did not report what he saw to the Physician or the Family Member.

A telephone interview was conducted with Nurse #1 on 8/13/2021 at 9:30 am. Nurse #1 stated on the evening of 8/9/2021 she was at the Nurses ' Station when Resident #1 walked up the hall with a Styrofoam food container in his hand and the DON screamed out and stated she thought she was going to be sick. Nurse #1 stated the DON said she saw Resident #1 pick a food tray out of the trash and something was moving in his hand and before she could stop him, he put something that looked like a mouse in his mouth. Nurse #1 stated Resident #1 would not open his mouth. Nurse #1 stated the DON left the unit. Nurse #1 stated she felt sick and went into the bathroom and when she came out Nurse Aide #1 yelled out and came to the nurses ' station. Nurse #1 stated Nurse Aide #1 told her Resident #1 spit up something that looked like grizzle and a tail. Nurse #1 stated she could not look at what

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Resident #1 had spit up because she was so sick, and she stated the DON did not look at what Resident #1 had spit up. Nurse #1 stated the DON notified the Administrator of the incident and she thought she was going to notify the Physician and document the incident.

An interview by phone was conducted with Nurse Aide #1 on 8/12/2021 at 7:05 pm and she stated on 8/9/2021 Resident #1 arrived in the dining room at supper and he spit out a greyish-brown ball of fur with a piece of grizzle in it. Nurse Aide #1 stated she picked up what was spit out in a glove and put it in the trash and then had Resident #1 open his mouth. Nurse Aide #1 stated there was greyish-brown fur on Resident #1 ' s tongue. Nurse Aide #1 stated she notified Nurse #1 immediately.

During an interview with the Administrator on 8/12/2021 at 6:39 pm she stated it was reported by Nurse Aide #1 on 8/9/2021 Resident #1 had fur in his mouth and grizzle that may have been a mouse tail. The Administrator stated the facility reported the incident to the Physician on 8/10/2021 when he arrived at the facility. The Administrator stated she had the facility ' s pest control provider check for any signs of mice on 8/11/2021 and the facility also had an education on what they should do if they saw pests in the facility 8/11/2021.

During an interview with Nurse Aide #2 on 8/13/2021 at 11:36 am she stated she did not witness the incident on 8/9/2021 when Resident #1 put something in his mouth, but she has observed him digging through the trash and getting other resident ' s food before, and she redirected him when he has the behavior.

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Physician was interviewed on 8/13/2021 at 1:55 pm and he stated he was notified on the morning after the incident, 8/10/2021, that Resident #1 may have swallowed a mouse. The Physician stated he did not assess Resident #1, write orders, or call Poison Control because he thought the Nurse Practitioner would be seeing Resident #1.

During an interview with the Representative from the facility ' s pest control company on 8/13/2021 at 4:20 pm he stated he had been coming to the facility for the past 4 months and he treated the building every month for bug control but had not seen signs of mice. He stated he had set traps outside the facility to keep mice from coming inside on 7/21/2021 during a routine pest control visit and he had inspected the facility on 8/11/2021 for any signs of mice and cockroaches inside the facility.

The facility ' s pest control company report dated 8/11/2021 stated the facility was inspected for rodent and cockroach activity and no activity was found. The report further stated exterior rodent bate traps were applied.

A Progress Note with a date of service of 8/12/2021 by the Nurse Practitioner stated she saw Resident #1 after staff reported he ingested a rodent. The Progress Note further stated the Nurse Practitioner called Poison Control and they suggested Resident #1 be monitored for fever, bleeding, and vomiting.

An interview by phone with the Nurse Practitioner on 8/13/2021 at 12:00 pm revealed she was told by the DON on 8/12/2021 Resident #1 may have

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ingested a mouse on Monday 8/9/2021. The Nurse Practitioner stated she learned about the incident from the DON when she was in the facility to see resident but had not been called in to see Resident #1. The Nurse Practitioner stated she had examined Resident #1 for any bite marks on his lips and mouth and did not see any. The Nurse Practitioner stated she was also concerned if Resident #1 had ingested a mouse he may have also ingested poison from the mouse and she also worried about what disease the mouse may carry. The Nurse Practitioner stated she called the NC Poison Control and was told Resident #1 should be monitored for fever, bleeding, and bloody diarrhea. The Nurse Practitioner did not write orders for monitoring for Resident #1.

During a follow up interview with the DON on 8/13/2021 at 3:26 pm she stated she had updated Resident #1 ' s care plan yesterday, 8/12/2021, to include his history of eating from the garbage after she reported to the Family Member, he may have ingested something unknown from the garbage on 8/9/2021. The DON stated the Family Member had stated he had a history of eating from the garbage and putting inedible items in his mouth. The DON also stated Nurse #1 should have documented the incident that occurred on 8/9/2021 in the medical record.
An interview and observation with Nurse Aide #5 on 8/13/2021 at 5:12 pm revealed she cared for Resident #1 frequently. Nurse Aide #5 stated Resident #1 wanders and gets into trash and other resident ' s food. Nurse Aide #5 stated Resident #1 had to be watched constantly and redirected. During the interview with Nurse Aide #5 on 8/13/2021 at 5:14 pm Resident #1 entered the dining room and was opening the cabinet

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doors and going through items in the cabinets. Nurse Aide #5 redirected Resident #1 to the table.

Nurse Aide #6 was interviewed on 8/13/2021 at 6:52 pm and he stated he was not told the signs and symptoms to monitor for if Resident #1 did ingest a mouse.

During an interview with Nurse #2 on 8/13/2021 at 6:53 pm she stated was not told what signs and symptoms Resident #1 should be observed for after the incident when he allegedly ingested a mouse. Nurse #2 stated Resident #1 wanders and has rummaged in the trash and she stated she redirects him

Nurse #4 was interviewed on 8/13/2021 at 7:01 pm and she stated she did not receive any instruction regarding what symptoms she should observe Resident #1 for after the possible ingestion of a mouse.

Nurse Aide #7 was interviewed on 8/13/2021 at 7:04 pm and stated she had not told what signs and symptoms to look after Resident #1 ' s incident where he may have swallowed a mouse. On 8/13/2021 at 8:12 pm the Administrator was notified of Immediate Jeopardy.

On 8/14/2021 the facility provided a Credible Allegation of Immediate Jeopardy Removal: Credible Allegation of Compliance F689.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
On 8.9.21, resident #1 was seen by DON and social worker with a string like object hanging

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from his mouth. DON and SW immediately approached resident and checked resident ' s oral cavity for any foreign objects but found none.
On 8.9.21 after incident DON failed to document and complete incident report, notify MD, notify RP, and update care plan. On 8.9.21, DON and/or Nurse #1 failed to document assessment of resident after incident.
On 8.9.21, twenty minutes after incident, nurse #1 alerted DON that resident had spit up an unidentified item. Nurse #1 failed to document findings and incident.
On 8.9.21, DON/and or nurse #1 failed to notify poison control for guidance on unidentified potentially harmful item.
On 8.9.21 DON/ and or nurse #1 failed to document attempts to notify RP.
All residents with identified behavior of placing items in mouth are at risk. Facility failed to initiate a care plan for the potential of placing non-food related items in mouth upon admission for resident #1 to address the prior history of the exhibited behavior. DON initiated a care plan on 8.12.21 for the exhibited behavior of placing potentially harmful items in mouth. All staff educated on care plan on 8.13.21 and 8.14.21 by Administrator and DON.
All residents are at risk for incident and/or accident. On 8.9.21 Nurse failed to document incident or notify resident physician or responsible party per facility policy.
Resident ' s RP was notified via cell phone by DON on 8.12.21.
Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete.
M.D. was notified on 8.10.21 by DON and RP was notified on 8.12.21 by DON.

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F 689	Continued From page 23 On 8.10.21 immediately upon noticing string like object hanging from resident #1 ' s mouth, DON states she swept resident ' s mouth for any signs of foreign objects. She found none. Director of nursing called poison control on 8.12.21 with recommendations to monitor for fever, vomiting or bleeding. The FNP completed assessment of resident #1 on 8/12/21 at 4:00 pm related to incident of ingesting potential harmful item in his mouth. FNP also notified poison control on 8.12.21 with same recommendations. Director of Nursing completed additional assessment of resident #1 on 8.13.21. Resident #1 will be monitored by licensed nurse for any change in condition to include fever, vomiting or bleeding as recommended by poison control. DON entered order to monitor for changes in condition for resident #1 on 8.13.21. Licensed and Registered Nurses were educated on 8.13.21 and 8.14.21 by Administrator and DON. On 8.13.21 Regional Director of Operations and Regional Clinical Director met with Administrator and Director of Nursing to review process for assessment and Care plan. Regional Director of Operations and Regional Clinical Nurse provided remediation education on policies for resident assessment and care plans on 8.13.21. MDS nurse will be educated by Administrator when MDS Coordinator returns from vacation. On 8.13.21 Regional Clinical Nurse met with the Director of Nursing and reviewed the facility ' s policy on documentation and notification of physician and resident representative. Regional Clinical Nurse provided remediation education to the Director of Nursing on facility policy for incident and accidents including notification of physician and family notification as of 8.13.21. On 8/13/21 Director of Nursing begin education to	F 689		

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all Nurses on facility policy for incident and accidents which included documentation of incident/accident, assessment of incident/accident, and notification to physician and representative. Director of Nursing will conclude education of all licensed Nursing staff on 8.14.21. As of 8.14.21 no licensed will be allowed to work prior to receiving education on incident and accident documentation. Starting 8.14.21 any agency or new licensed staff will be educated by the Director of Nursing or designee, on facility documentation and notification related to incident/accident prior to starting shift. Sign in sheets will be audited by DON or designee daily to ensure all new staff have signed.

Beginning on 8.13.21 Administrator and or Director of Nursing educated all staff on residents with behaviors of putting or ingesting something harmful in their mouth. Starting on 8.14.21 all new staff or agency staff will be educated on residents with behaviors related to potential for putting potential harmful things in mouth and/or digging in trash prior to working. Education to be completed by Administrator and DON, with Administrator and DON or designee educating any new staff to the facility. Daily schedule will be reviewed by Administrator, DON, or designee to ensure new staff educated as they come in, starting on 8.14.21.

On 8.13.21, DON initiated order for monitoring resident for signs and symptoms of ingesting potentially harmful items. Care plan was updated on 8.12.21 for behaviors of potentially ingesting potentially harmful items and digging in trash. On 8.14.21, all staff have been educated on monitoring for residents putting potentially harmful items in mouth and digging in trash.

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On 8.14.21, IDT team was in-service by Administrator related to care planning of behaviors of residents putting potentially harmful items in mouth or digging in trash.

Administrator will be responsible for making sure IJ removal plan is carried out and completed.

Facility alleges IJ removal as of 8.14.21.

Credible Allegation IJ removal
On 8/17/2021 a review was conducted of the plan to ensure those affected by the deficient practice. The facility updated Resident #1 ' s Care Plan to include a history of eating items out of the trash and putting non-edible items in his mouth on 8/12/2021. The Nurse Practitioner assessed Resident #1 and called Poison Control on 8/12/2021. A review of Resident #1 ' s medical record revealed there was a Nursing Progress Note each shift beginning 8/12/2021 to document signs of nausea, vomiting, diarrhea, and bloody stools. The Administrator was interviewed and stated the facility had reviewed all residents who scored as cognitively impaired on the BIMs (Brief Interview for Mental Status) and had evaluated them for the possibility of placing non-edible food items in their mouths on 8/14/2021. During the validation three other residents that were cognitively impaired were reviewed and two had care plans for potential to place non-edible objects in their mouths. Both residents were ambulatory and had behaviors like putting objects in their mouths. The other resident was bed bound and was at no risk of placing non-edible items in their mouth. The facility did in-service education with the Nursing Department which included care planning any resident that had behaviors of putting non-edible objects in their

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mouth on 8/14/2021. The education for the Nursing Department also included reporting of any change in condition or accident to the Physician and Responsible Party immediately. The in-service education included notifying Poison Control if needed and Emergency services if needed and then documenting what had happened and what was done for the resident in the resident ' s record. The facility also included education with all other staff (housekeeping, dietary, and maintenance) to report any time a resident is attempting to put something in their mouth or has put something non-edible in their mouth. Interviews were conducted with multiple staff members from each shift and different disciplines, and they were able to verbalize the correct information. The facility has included the in-service education in the new employee education and education for agency staffing beginning 8/14/2021.

2. Resident #5 was admitted to the facility on 4/22/21 and her cumulative diagnoses included stroke, dementia with behavioral disturbance, and generalized weakness.

A review of Resident #5 ' s Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 8/2/21. The resident was coded as having severe cognitive loss. For Activities of Daily Living (ADLs) the resident was coded as having required supervision with the support of one person for bed mobility, transfer (such as into and out of bed to a wheelchair), walking in the room, walking in the corridor, and moving about the unit. The resident was coded for having displayed verbal behavioral symptoms directed toward others (e.g. threatening others, screaming

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at others, cursing at others).

Resident #5 ' s care plan, documented the resident had a focus area for the resident having impaired cognitive function/dementia or impaired thought processes related to Alzheimer ' s, but the goals nor the interventions addressed the resident ' s behaviors.

On 8/13/21 the resident was seen for a psychiatry initial visit by a Geriatric Nurse Practitioner-Board Certified (GNP-BC). The GNP-BC recommended adding divalproex (an anticonvulsant medication which is also used to treat the manic phase of bipolar disorder (manic-depressive illness) Delayed Release (DR) 250 milligram (mg) twice a day and to continue the other psychotropic medications the resident was on.

a. Resident #6 was admitted to the facility on 11/7/16. The resident ' s cumulative diagnoses included: Dementia with behaviors, delusional disorders, psychoses, schizophrenia, schizoaffective disorder, anxiety, and depression.

A review of Resident #6 ' s Minimum Data Set (MDS) assessment revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 8/11/21. The resident was coded as having severe cognitive impairment. For Activities of Daily Living (ADLs) the resident was coded as having required limited assistance of 1 person for bed mobility, transfer (such is into and out of the bed to and from a wheelchair), locomotion both on and off of the unit. The resident was not coded for any behaviors during the assessment period.

Resident #6 ' s care plan included the following

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focus areas related to behavior: Verbally aggressive (yelling at other residents, accusing them of stealing her belongings), potential to be physically aggressive striking other residents related to dementia, impaired cognitive function/dementia related to dementia, delusional, psychosis, dementia in other diseases classified elsewhere with behavioral disturbance, other specified problems related to psychosocial circumstances, and level II Pre Admission Screening and Resident Review (PASRR). The resident ' s care plan was revised on 8/14/21.

An incident report dated 8/16/21 and timed 3:40 PM, which was completed by Nurse #5, was reviewed. The incident report detailed Resident #5 wandered into Resident #6 ' s room and Resident #6 asked Resident #5 to leave her room. Resident #5 walked over to Resident #6 and hit her across her face as was reported by Resident #6. Resident #6 provided further information that she then hit Resident #5 across her face. No injuries were observed and neither resident had any complaints of pain. Both residents were separated. There was no information in the incident report regarding further monitoring of either resident.

During an interview conducted on 8/24/21 at 12:14 PM with Nurse #5 she stated Resident #5 could be pleasant, but lately she had been getting riled up and was more agitated. She said the resident could get up and move around the dementia unit independently. The nurse further explained, recently, the resident had been getting into more verbal altercations with residents.

b. Resident #7 was admitted to the facility on 3/8/19. The resident ' s cumulative diagnoses

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included: Dementia, insomnia, generalized weakness, and anxiety.

A review of Resident #7 ' s MDS assessment revealed a quarterly assessment with an ARD of 8/11/21. The resident was coded as having severe cognitive impairment. For ADLs the resident was coded as having required supervision and setup help only for bed mobility, transfer (such is into and out of the bed to and from a wheelchair), walk in the room, walk in the corridor, locomotion both on and off of the unit. The resident was not coded for any behaviors during the assessment period.

Resident #7 ' s care plan included the following focus areas related to behavior: Elopement risk/wanderer related to dementia and the resident had a history of wandering aimlessly. There was also a focus area for the resident having the potential to be physically aggressive to staff and residents related to dementia. The resident ' s care plan was revised on 8/14/21.

An incident report dated 8/18/21 and timed 8:15 AM, which was completed by Nurse #6, was reviewed. The incident report detailed Resident #7 wandered into Resident #5 ' s room, Resident #5 asked Resident #7 to leave her room, and Resident #7 would not leave the room. The two residents then got into an altercation where they scratched each other. The information was documented as having been provided by a Nursing Assistant (NA) who had witnessed the altercation. The nurse documented the altercation resulted in Resident #7 receiving an abrasion to her upper chest area which was cleansed with wound cleanser and ointment was applied. There was no documentation regarding

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further monitoring or either residents for behaviors.

An additional incident report dated 8/18/21 and timed 8:15 AM, which was completed by Nurse #6, was also reviewed. The incident report detailed Resident #7 wandered into Resident #5 ' s room, Resident #5 asked Resident #7 to leave her room, and Resident #7 would not leave the room. The two residents then got into an altercation where they scratched each other. The two residents were separated by an NA. The information was documented as having been provided by a NA who had witnessed the altercation. The nurse documented the altercation resulted in Resident #5 receiving two skin tears to her right lower arm which resulted in a scant amount of blood observed. which was cleansed with wound cleanser, ointment, and a dressing was applied. There was no documentation regarding further monitoring of either residents for behaviors.

Review of a psychotherapy comprehensive clinical assessment dated 8/18/21 by a Doctor of Philosophy (PhD) psychologist. Resident #5 was seen for initial assessment of cognitive status, insomnia, and dementia behaviors. The PhD documented the resident was seen by the GNP-BC and recommended adding divalproex DR 250 mg BID. She further documented the resident was not appropriate for psychotherapy but encourages staff to have patient come out of room even if for brief periods at a time to either connect with other peers or maybe an activity, and to encourage to connect with resident to reduce isolation. The resident was determined to not be appropriate for psychotherapy and advised social work.

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During an interview conducted on 8/25/21 at 11:24 AM with NA #8 he stated he had seen Resident #5 and Resident #7 get into an altercation and he had also seen Resident #5 get into altercations with other residents. He said Resident #7 had grabbed Resident #5 and they were both trying to grab each other in Resident #7 ' s room. He said Resident #5 had also grabbed Resident #7 ' s shirt. He said he hadn ' t seen the whole altercation because he had just happened to have been passing by Resident #7 ' s room when the altercation was already underway. He said he had seen where Resident #7 had scratched at Resident #5 ' s chest. He said he had passed the room earlier and everything looked OK with both residents in the room earlier. He explained Resident #5 was all over the dementia unit and did not know where her room was. He said Resident #5 liked attention and if you gave her a lot of attention, she wouldn ' t do anything. He said once Resident #5 was with him and he was giving her attention, she was no problem for the rest of the day.

NA #5 stated during an interview conducted on 8/25/21 at 11:43 AM Resident #5 had been in several altercations with different residents. She stated there had been one day when Resident #5 was just fighting everyone. The NA stated she was also a medication aide and she had observed a pattern with Resident #5. She explained the resident would get up in the morning, eat her breakfast, take her medications, then take a nap, and when she would wake up from her nap she would be agitated. She further stated it was common for her to wander into other resident ' s rooms, sometimes it helped to

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redirect her, and sometimes it did not. She said when Resident #5 had an altercation with Resident #7 on 8/18/21, Resident # 5 had a scratch on her neck and Resident #7 had scratches on her arm. She said she had alerted Nurse #6 who came over to check on the residents. She said after the altercation with the two residents they had kept Resident #5 close to them, but she did not know if there was someone assigned to be with Resident #5. The NA said if there was a serious altercation, then a resident would have one to one. She said there was nothing specific set up for Resident #5. She said it helped with the resident if someone were to spend time with her and give her attention, but most of the altercations come when she goes into other resident ' s rooms and argues with them that it is her room.

An interview was conducted on 8/25/21 at 10:16 AM with Nurse #6. She stated she was told by NA #8 and NA #5, Resident #7 had gone into Resident #5 ' s room and she wouldn ' t leave, and the two residents had "gotten into it," this had happened on 8/18/21. She explained when she arrived on the dementia unit both residents had scratches and both residents had required treatment for the scratches. Resident #5 had scratches to her chest and Resident #7 had scratches on her arm. She said both residents were upset, excited, and agitated a little bit over what had happened.

An observation conducted of Resident #7 on 8/25/21 at 12:00 PM revealed the resident had two separate dry and intact abrasions on her right arm. One skin tear was approximately 1 centimeter (cm) long and was L shaped. The other skin tear was approximately 5 millimeters

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(mm) long and was crescent shaped.

c. Resident #8 was admitted to the facility on 3/27/19. The resident ' s cumulative diagnoses included: dementia with behavioral disturbance, depression, anxiety, generalized weakness, insomnia, and psychosis.

A review of Resident #8 ' s MDS assessment revealed a quarterly assessment an with ARD of 8/11/21. The resident was coded as having severe cognitive impairment. For ADLs the resident was coded as having required supervision or setup help of 1 person for bed mobility, transfer (such is into and out of the bed to and from a wheelchair), walking in the room, walking in the corridor, locomotion both on and off of the unit. The resident was coded for behavioral symptoms not directed towards others during the assessment period.

Resident #8 ' s care plan included the following focus areas related to behavior: Elopement risk/wanderer related to resident wanders aimlessly, dementia, Alzheimer ' s. Behavior problem related to Alzheimer ' s dementia-there were multiple dated entries with behaviors including attempted elopement, pulling fire alarm, verbally aggressive to staff, wandering into other resident ' s rooms, refusing medications, combative towards staff, ripped air conditioning cover off, attempted to take another resident ' s walker, physical altercation with other resident, and threw lunch tray. The resident ' s care plan was revised on 8/14/21.

A pharmacist review note dated 8/20/21 and timed 9:36 AM documented Resident #5 had altercations with other residents on 8/16/21 and

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8/18/21. The resident had other behaviors which included cussing and screaming at other residents while walking down the hall, will calm down, and then start back crying or screaming. The resident ' s psychotropic medications included haloperidol 1 milligram (mg) three times a day and trazodone 50 mg each evening at bedtime. There were no recommendations regarding the resident ' s medication at the time of the review.

An incident report dated 8/20/21 and timed 7:23 PM, which was completed by Nurse #7, was reviewed. The incident report detailed Resident #8 was hit in the center of the back by Resident #5. The description included Resident #8 was walking by Resident #5 when the Resident #8 caused the aggressive behavior by Resident #5. There were no identified injuries for Resident #8. There was no information in the incident report regarding further monitoring of either resident.

A second incident report dated 8/20/21 and timed 7:39 PM, which was completed by Nurse #7, was also reviewed. The incident report detailed according to staff Resident #5 hit Resident #8 in the center of the back. The description included Resident #5 had very aggressive behaviors. There were no identified injuries for Resident #5+. There was no information in the incident report regarding further monitoring of either resident.

A phone interview was conducted on 8/25/21 at 2:54 PM with Nurse #7. The nurse stated Resident #5 was agitated all of the time since 7/4/21 and she had documented the resident ' s agitation. The nurse stated she believed Resident #5 was a threat to other residents. She

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explained on 8/20/21 Resident #5 had hit Resident #8.

d. Resident #4 was admitted to the facility on 1/20/20. The resident ' s cumulative diagnoses included: stroke, dementia with behaviors, generalized weakness, Huntington ' s Disease, and insomnia.

A review of Resident #4 ' s MDS assessment revealed a quarterly assessment with an ARD of 7/23/21. The resident was coded as having moderate cognitive impairment. For ADLs the resident was coded as having required supervision of 1 person for bed mobility, transfer (such is into and out of the bed to and from a wheelchair), walking in the room, walking in the corridor, locomotion both on and off of the unit. The resident was coded for physical behavioral symptoms directed towards others during the assessment period.

An incident report dated 8/22/21 and timed 8:15 AM, which was completed by Nurse #8, was reviewed. The incident report detailed Resident #5 went into Resident #4 ' s room and when Resident #4 attempted to get Resident #5 out of her room, Resident #5 bit Resident # on her left lower arm, breaking through the skin. Resident #3 reported to the nurse Resident #5 had bit her. The injury was cleansed, ointment applied, a dressing applied, and the resident was sent to the Emergency Room (ER). There was no information in the incident report regarding further monitoring of either resident.

Resident #4 had a Weekly Skin Review dated 8/22/21 and timed 8:30 AM, which was completed by Nurse #8. The resident was documented as

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having had a new open are which was a large bite mark to the left lower arm with an open area. The wound contained pink skin tissue and there was some yellowish drainage. The wound was 4.2 centimeters (cm) long, 3.0 cm wide, and 0.1 cm deep. The wound was cleansed with wound cleaner, triple antibiotic ointment applied, and covered with a dry dressing. The comments section documented Resident #4 sustained a bite to the left forearm on 8/22/21, was seen in the ER, and returned to the facility with orders for 2 different oral antibiotics for prevention of infection.

A second incident report dated 8/22/21 and timed 9:25 AM, which was completed by Nurse #8, was also reviewed. The incident report detailed Resident #5 went into the room of Resident #4. When Resident #4 attempted to get Resident #5 out of her room, Resident #5 bit Resident #4 on the left lower arm. Further description included Resident #5 was screaming and cussing at the nurse. There was no information in the incident report regarding further monitoring of either resident.

A Situation Background Assessment Recommendation (SBAR) report dated 8/22/21 and timed 10:44 AM, which was completed by Nurse #8 documented the resident evaluation for this change in condition were: physical aggression and verbal aggression.

An interview was conducted with NA #8 on 5/25/21 at 11:24 AM. The NA stated he had seen Resident #5 coming out of Resident #4 ' s room, he had not seen Resident #4 get bit, he said he separated the residents, and then went and told the nurse. He explained Resident #4 was talking loudly and he thought she was talking to herself

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until he had seen the two residents had been into an altercation and Resident #4 had been bit. He said he had been at the facility when Resident #5 had been in confrontations with others. He stated he kept Resident #5 with him for the rest of the shift.

A phone interview was conducted on 8/25/21 at 5:57 PM with Nurse #8. The nurse stated she had observed Resident #5 having been aggressive whenever she had worked at the facility. She explained when Resident #5 had bit Resident #4 the wound required treatment because the bite had actually broken through the skin. She said another reason for Resident #4 to go to the hospital was for her to receive a tetanus shot. She stated she had been aware Resident #5 had previous incidents but was not aware the altercation on 8/22/21 with Resident #4 was the fourth altercation since 8/16/21, a period of less than a week. She explained after the altercation between Resident #5 and Resident #4, the staff kept a "close eye" on Resident #5 by walking with her and keeping her near staff.

Review of the ER provider note dated 8/22/21 and timed 10:49 AM revealed Resident #4 was evaluated for a human bite to the left forearm. The resident stated she was not in an argument or altercation with Resident #5. The resident was observed to have a bruise and areas of abrasion to the left forearm. The resident was discharged back to the facility with two oral antibiotics including doxycycline hyclate 100 mg, one capsule, two times a day, for 10 days, and Metronidazole 500 mg, one capsule, three times a day, for 10 days. The resident received a tetanus shot while in the ER. There was no documentation regarding treatment or size of the

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wound. The form was unsigned as to what staff member had completed it.

During an interview conducted in conjunction with an observation on 8/24/21 at 12:07 PM with Resident #4 she stated Resident # 5 had bit her and pointed toward her left forearm. The resident further stated Resident #5 was in the hospital at the time of the interview. The resident was observed to have an abrasion on her arm with bruises near and at the base of the abrasion.

A Skin Care Alert form for Resident #4, which was dated 8/23/21, and was not timed, was reviewed. The form documented Resident #4 had a bite wound to the left forearm which measured 4.2 centimeters (cm) long by 3.0 cm wide by 0.1 cm deep with irregular edges and scant serous drainage. The wound was washed, topical antibiotic ointment was applied, and a dry dressing was applied. There was no information on the form as to who had completed the form.

An interview was conducted on 8/25/21 at 10:04 AM with the Assistant Director of Nursing (ADON). She stated she had changed the dressing on Resident #4 and the resident had an order for a daily dressing changed which was to cleanse the wound with wound cleanser, apply triple antibiotic ointment, and cover with a dry dressing. She said the wound Nurse Practitioner (NP) was going to see the resident on 8/25/21, the date of the interview. She explained the resident was also on two oral antibiotics, flagyl and doxycycline. She said the bite was not very deep, there were no teeth marks, there was an abrasion and bruising.

e. Resident #10 was admitted to the facility on

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7/9/21. The resident ' s cumulative diagnoses included: Dementia, generalized weakness, and depression.

A review of Resident #10 ' s MDS assessment revealed an admission assessment with an ARD of 7/14/21. The resident was coded as having severe cognitive impairment. For ADLs the resident was coded as being independent or having required supervision or setup help of 1 person for bed mobility, transfer (such is into and out of the bed to and from a wheelchair), walking in the room, walking in the corridor, and locomotion on the unit. The resident was not coded for behavioral symptoms during the assessment period.

Resident #10 ' s care plan included the following focus areas related to behavior: Adjustment issues to admission affecting her mood. The resident ' s care plan was revised on 8/14/21.

An incident report dated 8/23/21 and timed 3:12 PM, which was completed by Nurse #1, was reviewed. The incident report detailed Resident #5 was ambulating through the hallway and was witnessed pushing Resident #10 as she passed by the resident. No injuries noted and the residents were separated immediately. There was no information in the incident report regarding further monitoring of either resident.

A progress note dated 8/23/21 and timed 4:25 PM by Nurse #1 documented the Assistant Director of Nursing (ADON) reported that the Nurse Practitioner (NP) gave a new order to send the resident to the ER for evaluation due to behaviors. Emergency Medical Services (EMS) arrived, and the resident was transferred to the

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ER.

Review of a NP note dated 8/23/21 and timed 4:56 PM revealed the resident had Alzheimer ' s Disease with behaviors. Resident #5 was observed shoving another resident in the hall. She was very agitated/restless and was wandering throughout the halls of the locked unit. The facility staff reported the resident was not easily redirected, and the resident had been displaying progressive agitation and behaviors.

A phone interview was conducted on 8/25/21 at 2:54 PM with Nurse #7. The nurse stated Resident #5 was agitated all of the time since 7/4/21 and she had documented the resident ' s agitation. The nurse stated she believed Resident #5 was a threat to other residents. She explained on 8/20/21 Resident #5 had hit Resident #8.

A review was completed of Resident #5 ' s hospitalization, from 8/23/21 through 8/25/21. In the ER the resident was observed to have been confused, unable to answer questions, tense/restless, and tearful throughout the physician interview. The physician felt the resident was medically stable. The psychiatric evaluation included observations of the resident having been very calm, and cooperative, but did display advanced dementia. Based on the information from the physician and the psychiatric evaluation the resident did not require psychiatric hospitalization. The resident was aggressive as reported by the sitter in the ED. The resident was started on Depakote 125 mg orally three times a day for mood stability.

During interviews conducted with Nurse #1 on

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8/24/21 at 12:20 PM and 3:48 PM. She stated Resident #5 had been displaying increased agitation and behaviors, and on 8/23/21 had pushed a resident. She said Resident #5 had pushed her pretty hard and was arguing with Resident #10. She further stated the NP was at the facility and the NP had made the resident one to one at the time. The NP had the resident sent out to be medically cleared at the time, to rule out a urinary tract infection, abnormal labs, etc ... She explained she felt like Resident #5 was sundowning (a behavior with dementia residents where they become agitated when the sun sets in the evening), but it seemed to be happening all day. She said she had observed the all-day long behavior for the last week to two weeks. She also stated the resident used to be tearful, but now was just agitated. She said the NP had said the resident was becoming more of a safety risk. She stated Resident #5 did not receive any as needed medications for behavior and all of her psychotropic medications were scheduled.

An interview was conducted with the Assistant Director of Nursing (ADON) on 8/25/21 at 10:04 AM and she stated Resident #5 had been having more aggressive behavior, cried a lot, and at times was resistant to care. She also said the resident wandering was a new behavior.

NA #9 stated during an interview conducted on 8/25/21 at 11:34 AM she had seen altercations between Resident #5 and other residents, such as one time in the activities room when she had been in "everybody ' s faces." She said she remembered the day she had bit Resident #4, and she felt she had been extremely agitated that day as well because she had been out in the hallway hollering. She explained there was not

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anything in place to help settle Resident #5 down, although sometimes she is able to get her cookies, drinks, or even take her outside, to help calm her down. She further stated she did feel Resident #5 had become more agitated recently and been lashing out at everyone.

An observation conducted on 8/25/21 at 11:57 AM revealed Resident #5 had returned to the facility and had a staff member with her for one-to-one monitoring. The resident was in the dining room watching a movie, then left the dining room, and ambulated in the hall. NA #9 was the one-to-one staff member with the resident.

An interview was conducted on 8/25/21 at 1:15 PM with NA #10. She said she had been working in the dementia unit for the past two weeks and she had seen Resident #5 walk around the unit, get really agitated quickly, yell at the residents and staff, not anyone in particular, and has observed her in verbal altercations. She said the verbal altercations were interrupted before they developed into something else. She said to help the resident calm down she would walk with her. She further explained it wasn ' t anything which was written down anywhere, it is just something which helps to calm her down. She said she had seen other people do different things with Resident #4 to help calm her down and maybe the information of what works with the resident should be shared.

A phone interview was conducted on 8/25/21 at 3:39 PM with the NP. She said she had sent out Resident #5 to the ER on 8/23/21 due to her behaviors, which included hitting, shoving, and biting. She explained Resident #5 had been sent to the ER due to a safety concern for other

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residents. She said she had seen Resident #5 shove Resident #10 and she had not shoved her that hard. She said they had tried an antipsychotic medication, but she was concerned the resident may have had a medical condition which may have been contributing to her behaviors, such as a Urinary Tract Infection (UTI) and she wanted the medical condition ruled out prior to adjust medications or seeking in patient psychiatric care. She said she had been informed by the staff at the facility the resident ' s behaviors had been escalating over the past week to the point where the resident was very agitated, and they could not have a resident in the facility striking other residents. She further stated when she had seen the resident on 8/23/21 she was unable to even examine the resident because of the condition she was in and the resident was not appropriate for the facility at the time. The resident ' s behaviors included her speaking to herself, going into and out of other resident ' s rooms, agitated, to the point where she had asked staff to keep the resident under one-to-one supervision. She said she felt as the resident ' s behaviors had been progressive.

During an interview conducted on 8/26/21 at 9:50 AM with the facility Social Worker (SW) he stated he had started a behaviors care plan for Resident #5 on 8/24/21, the day after she had been sent out to the ER. He explained the resident had verbal behaviors before that and had some incidents before he started the care plan for her behaviors. He said during the morning meetings, which were held Monday through Friday, they would review and discuss items which had been entered into residents ' progress notes. He said he was the person who worked on the care plans and entered in focus areas. He said one of the

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interventions which was put into place after the resident returned from the hospital was one-to-one supervision and she was on the list for a psych eval. The SW reviewed Resident #5 ' s electronic medical record and stated she had been seen by psych services on 8/16/21, 8/18/21, had another altercation on 8/18/21, another altercation on 8/20/21, bit another resident on 8/22/21, had pushed another resident on 8/23/21, and was sent out to the ER on 8/23/21. He stated he felt the facility had addressed the resident ' s behavior and was trying to work with psych services, but he wasn ' t clinical so he could not speak on other interventions. He said there were no interventions put into place when the resident ' s behaviors were escalating such as 15-minute checks or one-to-one monitoring prior to hospitalization.

During an interview with the administrator conducted on 8/26/21 at 10:40 AM she stated during the morning meeting they would review any changes with residents and the current person assigned to update care plans was the SW. Regarding Resident #5, she explained the resident had been at the facility since May 2021 and prior to the first altercation, the resident was teary, but OK. She explained after the first altercation she had NA #10 in the dementia unit to assist with activities and with Resident #5. She said the resident was sent out the ER on 8/23/21 to be medically cleared with the hope of getting the resident admitted to the psych center in Thomasville. She said there had been several changes at the facility including a new medical director, new MDS coordinator, and there was a goal of conducting every other week psych meeting to discuss psych issues, concerns, medications with their residents, and had their

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F 689	Continued From page 45 first meeting on 8/4/21, but did not have a second meeting. All of the residents couldn ' t be reviewed at each meeting, and Resident #5 was to be discussed at the second meeting, which did not happen. The administrator further stated Resident #5 was on one-to-one right now and would continue on one-to-one until her behaviors were managed. She explained the resident was seen by a psych NP on 8/13/21 and then by a Doctor of Philosophy (PhD) psychologist on 8/18/21 who found the resident was not appropriate for talk therapy. She said the resident ' s care plan should have been updated for behaviors during the morning meeting.	F 689		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of	F 886		10/8/21

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asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

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F 886	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with agency staff the facility failed to ensure staff were COVID tested per the facility's Infection Prevention and Control policy and procedure and the Centers for Medicare and Medicaid Services (CMS) guidelines which indicated testing should be done weekly if the county positivity rate was greater than 5% for 2 of 3 staff reviewed for facility testing and the facility failed to monitor all staff were tested before allowing them to work during July 2021. Findings included: A review of the facility's Coronavirus Testing Policy and Procedure, which was revised on 7/1/2021, indicated the facility would test staff for the COVID-19 virus once a week if the county positivity rate was 5% to 10%. The facility's Coronavirus Testing Policy and Procedure did not indicate how staff and testing was monitored to ensure staff were not allowed to work when they had not been tested. A review of the information provided by the facility for the COVID-19 testing of staff during July 2021 when the county positivity rate was above 5% revealed they failed to test staff weekly for 3 of 4 weeks. The facility's county positivity rates for the week of July 5, 2021 was 5.8%; the week of July 19, 2021 was 7.2%; and the week of July 26, 2021 was 11.4%. The facility did not test staff for the week of July 5, 2021, July 19, 2021, and July 26, 2021. Dietary Aide #3 was interviewed on 8/25/201 at 4:20 pm and she stated she tested positive on	F 886	1. The Coronavirus Testing Policy and Procedure will include how staff will be monitored to ensure staff are not allowed to work when they have not been tested. A staff roster to include agency staff, housekeeping, therapy, dietary, laundry will be utilized to ensure that any staff working in the facility is current with COVID testing requirements in accordance with CMS guidelines. 2. The COVID test will be reviewed for the last 30 days by the Administrator/designee to ensure test have been completed as required by 9/30/21 3. Staff will be reeducated by the Director of Nursing/ designee by 9/30/21 on the COVID 19 testing and screening policy. In addition, other staff to include agency, dietary, housekeeping, therapy, and laundry staff will be reeducated by the DON/designee to ensure that they are following the CMS guidelines for Coronavirus testing and will be made aware that they will not be allowed to work until they are tested as required. All new staff and agency will be educated on COVID 19 testing prior to starting a shift. Administrator/Designee will review staff roster for COVID 19 testing weekly to ensure staff have been tested as per current testing requirement at the time of testing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 886	Continued From page 48 7/28/2021. Dietary Aide #3 stated she got sick at work on 7/28/2021 and the facility tested her for COVID-19 due to her symptoms, and she had not been tested had a routine COVID-19 test that week. An interview was conducted with Dietary Aide #1 on 8/25/2021 at 6:15 pm. Dietary Aide #1 stated she had not been tested for COVID-19 at the facility throughout July 2021 but had been tested weekly at her other job. Dietary Aide #1 stated she did not have any symptoms until after she tested positive for COVID-19 on 8/4/2021. Dietary Aide #1 stated she was tested by the facility because Dietary aide #3 tested positive. Dietary Aide #1 stated the facility had not been offering testing weekly through July until Dietary Aide #3 tested positive on 7/28/2021 and then they tested all the staff. During an interview with Dietary Aide #2 on 8/25/2021 at 4:25 pm she stated she had not been tested for COVID-19 for 3 weeks until Dietary Aide #3 tested positive and then she was tested on 7/30/2021. Dietary Aide #2 stated she did not have any symptoms before or after testing positive on 7/30/2021. An interview was conducted with Nurse #9 on 8/26/2021 at 10:32 revealed she had done the testing for COVID-19 twice a week but sometime in June or July 2021 the Director of Nursing told her they would be testing once a month, using a rapid COVID-19 test. Nurse #9 stated she did not monitor if all staff were tested when she did the COVID-19 tests, but she did fill out a form for each person she tested. The previous Director of Nursing (DON) was	F 886	All new staff will be educated on testing and screening upon arrival to the building as part of facility orientation. 4. The COVID testing will be reviewed by the interdisciplinary team in the monthly QAPI committee meeting for at least three months. The interdisciplinary team will recommend revisions to the plan as indicated to maintain substantial compliance. 5. Date of compliance 10/8/21	

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F 886	Continued From page 49	F 886		

interviewed on 8/27/2021 at 10:12 am and she stated she had been the Director of Nursing during June and July 2021. The previous DON stated sometime at the end of June 2021 the facility went to testing 1 x monthly and then there were positive staff at the end of July and the facility went back to testing 2 x weekly. The previous DON stated their county positivity rate was very low in July 2021 and she was told by the Administrator the facility could start COVID-19 testing 1 x month in July. The previous DON stated Nurse #9 was assigned to testing staff and if she was not available the Assistant Director of Nursing would test staff. The previous DON also stated she did not review the COVID-19 test results to make sure everyone was tested before allowing them to work and she did not know if anyone was checking to make sure staff were tested.

During an interview with the Administrator on 8/27/2021 at 10:38 am she stated staff were being tested twice weekly at present since three dietary staff tested positive for COVID-19 at the end of July 2021. The Administrator also stated the dietary staff do not leave the kitchen area and the nursing staff pick up the trays that are left outside the kitchen door. She stated the facility had gone to monthly testing in July because they had not had a positive staff or resident since January 2021. The Administrator stated she was told in February when she spoke with the Health Department the facility could go to monthly COVID-19 testing. The Administrator stated after Dietary Aide #3 developed symptoms while at work and tested positive for COVID-19 the staff and residents were tested all tested and the facility began outbreak testing. The Administrator stated no residents had tested

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F 886	Continued From page 50 positive. The Health Department Representative was interviewed on 8/31/2021 at 11:46 am and stated the facility should have COVID-19 test staff 1 x week during July 2021, per CDC guidelines and they had not been told to test 1 x monthly. She stated the only contact she had with the Administrator was on 8/5/2021 when the Administrator emailed stating they had an outbreak of three staff that tested positive for COVID-19 and she directed them to begin testing 2 x weekly. On 9/3/2021 at 2:16 pm a follow-up interview was conducted with the Administrator and she stated 25% of the facility's staff and 67% of the facility's residents are vaccinated for COVID-19.	F 886		