STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AND REHABILITATION	38 CARTERS ROAD GATESVILLE, NC 27938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/14/22 through 3/17/22. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event #KETI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/14/22 through 3/17/22. Event # KETI11 1 of the 3 complaint allegations was substantiated resulting in deficiency. Intake #s: NC00185087, NC00183972	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assess a resident for self-administration of medication for 1 of 1 resident observed to have medication in the room. (Resident #26) The findings included: Resident #26 was admitted to the facility on 12/6/19 and had a diagnosis of type 2 diabetes mellitus and hypertension. The resident's care plan dated 1/20/22 did not include the self-administration of medication. There was not an assessment of Resident #26 in	F 554	F-554 1. On 3/14/22 Resident #26 took his remaining pills (medication) without any problems. His care plan was updated to reflect checking the residents' mouth after medication administration. Nurse #4 was educated on 3/14/22 by the Regional Director of Clinical Services. 2. On 3/15/22 during lunch and facility rounds, residents were observed to ensure medication were not left in the room nor experiencing swallowing concerns.	4/8/22

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

Electronically Signed | 04/07/2022

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F 554	Continued From page 1 the medical record to determine if it was safe for the resident to self-administer medications. The Quarterly Minimum Data Set (MDS) Assessment dated 1/20/22 revealed Resident #26 was cognitively intact and required limited to extensive assistance with most activities of daily living (ADLs) and was independent with eating. On 3/14/22 at 10:21 AM Resident #26 was observed lying on the bed with a cup containing 3 tablets sitting on the bedside table. Resident #26 stated he had asked the nurse to sit the cup on the table and he told her he would take them. An interview was conducted with Nurse #4 on 3/14/22 at 10:27 AM. Nurse #4 stated Resident #26 was sitting up on the side of the bed and took all his medications in her presence. Nurse #4 stated Resident #26 must have spit some of his pills back into the cup. Nurse #4 stated that she should have stood at the resident's bedside to make sure that he swallowed all the medication. An entry on Resident #26's care plan dated 3/14/22 noted the following "Resident had a history of spitting out medications once nurse exits room. Check mouth after medications given to ensure swallowed." An interview with the Director of Clinical Nurse Services on 3/17/22 at 3:39 PM revealed that she expected that the nurse would not have set the medications in a cup at the bedside. The Clinical Services Director further stated that the nurse should have ensured that Resident #26 swallowed the medication.	F 554	3. The Director of Nursing or Assistant Director of Nursing educated all facility nurses and medication aides on monitoring residents during medication administration to ensure mediation are being taken as ordered by the physician. Newly hired facility and agency licensed nurses and Medication Aides will receive education prior to working as a part of the orientation process. 4. The Director of Nursing or Assistant Director of Nursing will complete monitoring/observation during medication administration of three (3) residents one (1) time a week for four (4) weeks, weekly for eight (8) weeks and as necessary. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance.	
F 607 SS=G	Develop/Implement Abuse/Neglect Policies	F 607		4/8/22

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F 607	Continued From page 2 CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to implement their abuse policy and procedure by not reporting Resident to Resident altercation to the facility Administrator immediately for 2 of 2 Residents reviewed (Resident #151 & #41) for abuse. The findings included: The facility's policy titled "Abuse, Neglect, and Exploitation" updated on 10/22/20 stated reporting of all alleged events will be made to the facility Administrator immediately. Resident #41 was admitted to the facility on 8/5/2020 with diagnosis that included anxiety. His MDS dated 10/23/21 indicated he was cognitively intact. Resident #151 was admitted to the facility on 11/5/21 with diagnoses that included history of seizures, stroke like episode, and psychosis. His Minimum Data (MDS) dated 12/14/21 indicated	F 607	F-607 1. The facility is unable to correct this matter regarding the notification of the Administrator for the resident-to-resident altercation between resident #151 and resident #41. 2. On 3/22/22, the Director of Nursing completed an audit of reported abuse incidents from 2/6/22-3/6/22 to ensure all incidents had been reported to the Administrator. The Administrator was updated accordingly of any incidents that occurred and there was no documentation of the Administrator not being made aware. 3. All staff were educated on notifying the Director of Nursing and Administrator of resident-to-resident altercations at the time the incident occurs as the Administrator is the designated Abuse	

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F 607	Continued From page 3 he was severely cognitively impaired. A telephone interview was completed on 3/15/22 at 3:10pm with Nurse #5. She indicated she was coming down the hallway at approximately 9:45pm on 12/26/21 and heard Resident #41 yelling. She went towards his room to investigate and at that point she saw both Residents (Residents #151 and #41) in the doorway of Resident #41's room. Nurse #5 indicated Resident #151 proceeded to strike Resident #41 on the side of the face with his closed hand. She continued to state Resident #41's wheelchair rolled out from under him, and he sat down on the floor and Resident #151 became unsteady and fell on his stomach. Nurse #5 indicated he did not hit his head, nor complain of pain after the fall. She stated she attempted to get to Resident #151 to redirect him before he acted out but was not fast enough. Nurse #5 stated Resident #151 had no complaints of pain after the fall. She escorted him back to his room and assisted him into a reclining chair to rest. She stated she notified the Residents' responsible parties, the former Director of Nursing (DON), and the Physician. Nurse #5 stated she was instructed by the DON to observe both Residents the rest of her shift. She stated she overlooked writing a progress note regarding the incident between Resident #151 and #41 and felt she was following the correct steps with notifying the DON regarding the event and was not aware she needed to contact anyone else. A telephone interview was completed on 3/16/22 at 4:10pm with the former Director of Nursing. She indicated she was not notified by Nurse #5 during the evening of 12/26/21 regarding the Resident-to-Resident altercation.	F 607	Coordinator and will be responsible for the timely reporting to NC state agencies for all allegations of abuse. Effective 4/8/22, all staff have been educated on the facility Abuse and Neglect policy and reporting all allegations of abuse to the Administrator (Abuse Coordinator) immediately. During education, all staff were questioned if they have witnessed or had heard of any additional abuse allegation and no additional concerns were reported. Newly hired facility and agency staff will receive education prior to working as part of the facility orientation. 4. Effective 4/8/22, the Administrator or Social Worker will complete abuse questionnaires with 5 random staff members to ask if they have witnessed or heard of any abuse allegations. Abuse reportable will be reviewed to ensure timely reporting of abuse allegations to the Administrator. Monitoring will be completed 1X week for 4weeks and 1X a month for 2 months as needed to ensure compliance. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with Abuse reporting.	

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F 607	Continued From page 4 An interview was completed with the Administrator on 3/15/22 at 9:30am. The Administrator stated Nurse #5 did not notify her when the event took place on 12/26/22. She indicated she was not made aware of the incident until she arrived at the facility on 12/27/21. She stated once she was fully aware of the event's details, it was around 5:00pm on 12/27/22.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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.	F 656		4/8/22

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F 656	Continued From page 5 (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 observation, record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident #103) with an indwelling urinary catheter. The findings included: Resident #103 was admitted to the facility on 2/2/22 with diagnoses that included chronic kidney disease with urinary outlet obstruction and type 2 diabetes mellitus with other kidney complications. Resident #103's admission minimum data set (MDS) assessment dated 2/23/22 revealed the resident had moderate cognitive impairment, required extensive assistance to total dependence for activities of daily living (ADLs) from staff except for eating. He had an indwelling catheter and was frequently incontinent of bowel. A review of the Care Area Assessment with an	F 656	F-656 1. Facility failed to develop a comprehensive, individualized care plan for Resident #103 that addressed the presence of indwelling urinary catheters. Comprehensive, individualized care plan was completed for Resident #103 on 03/18/22 by the Regional MDS Coordinator. 2. All current residents with indwelling urinary catheters will be audited by the Interdisciplinary Team (IDT) to include the Administrator, Director of Nursing and Assistant Director of Nursing, Wound Nurse, Social Worker and MDS Coordinators to ensure a comprehensive, individualized care plan for this area are completed. This audit will be completed by 4/8/22. 3. Regional MDS Consultant will educate	

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F 656	Continued From page 6 assessment reference date (ARD) of 3/14/22 indicated that the urinary catheter should have been addressed in the care plan. An observation of Resident #103 was conducted on 3/14/22 at 9:43 AM. Resident #103 had an indwelling urinary catheter. An interview was conducted with the MDS (Minimum Data Set) nurse on 3/17/22 at 11:00 AM. The MDS nurse stated that the urinary catheter should have been included in Resident #103's care plan. An interview was conducted with the Regional Director of Clinical Services on 3/17/22 at 3:53 PM. The Clinical Director stated the urinary catheter should have been included in Resident #103's care plan.	F 656	MDS nurse on completing comprehensive, individualized care plans on or before the 21st day of stay for the resident and updating the care plan during the quarterly assessment, as well as individualizing care plans with changes. Education will be added to new hire orientation. This education was completed on 04/07/22. Director of Nursing or designee will audit 3 residents with indwelling urinary catheters 3x per week x 4 weeks then weekly x 8 weeks to ensure they have an accurate complete comprehensive individualized care plan. 4. Administrator will review the results of the weekly audit to ensure the completion and individualization of the comprehensive care plans with indwelling urinary catheters. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/8/22

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F 657	Continued From page 7 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party (RP) interview, and staff interviews, the facility failed to invite the RP to a care plan meeting for 1 of 24 residents reviewed for care plan. (Resident #45). Findings included: Resident #45 was admitted to the facility on 11/12/21 with diagnoses which included stroke and traumatic brain injury. Record review revealed an initial care plan meeting was completed on 11/12/22 with Resident #45 ' s RP. Record review of Minimum Data Set (MDS) Admission Assessment dated 11/24/21 revealed	F 657	F-657 1. Resident #45 and his Responsible Party (RP) had a care planning meeting on 03/17/22. 2. All current residents care plan meeting schedule will be audited by the Interdisciplinary Team (IDT) to include the Administrator, Director and Assistant Director of Nursing, Wound Nurse, Social Worker and MDS Coordinators to ensure a care plan meeting has been scheduled upon admission and quarterly with the resident and/or Responsible Party. This audit will be completed by 4/8/22.	

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F 657	Continued From page 8 Resident #45 had severe cognitive impairment. During an telephone interview on 3/15/22 at 9:46 AM Resident #45 ' s Responsible Party (RP) revealed that she participated in an initial care plan meeting on the day of admission but was not aware of a care plan meeting was scheduled since the initial meeting. The RP stated that she was told that the facility would schedule a full care plan meeting with other departments in approximately 3 weeks. Resident #45 ' s RP stated she did not hear from the facility to schedule the meeting and was not aware if the meeting had taken place. During an interview on 3/15/22 at 3:44 PM the Social Worker revealed the MDS Nurse was responsible to schedule the care conferences. She stated she sent care plan invitation once the schedule was received by MDS. The Social Worker stated she was unable to find an invitation for care plan meeting for Resident #45 ' s RP and she was unable to remember or locate documentation that a care plan meeting took place as required for Resident #45. During an interview on 3/15/22 at 4:03 PM the MDS Nurse stated Resident #45 ' s care plan meeting was to be scheduled around 12/9/21 based on the date of the MDS Admission Assessment. She stated she wrote his name on her list to schedule but was unable to state if she sent the information to the Social Worker to send out the invitation to Resident #45 ' s RP. The MDS Nurse was unable to remember or locate information that a care plan meeting was held since the 11/12/21 meeting for Resident #45. During an interview on 3/17/22 at 4:45 PM the	F 657	3. The Regional Director of Reimbursement will educate the MDS nurse and IDT team on routine scheduling of care plan meeting with resident and/or responsible Party. Education will be added to new hire orientation. This education was completed on 04/07/22. 4. The Director of Nursing or Assistant Director of Nursing will complete weekly audits of the care plan schedule to ensure residents and/or the responsible party are being invited to the meeting. Monitoring will be completed once (1) a week for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with care plan meetings.	

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F 657	Continued From page 9 Administrator revealed the Social Worker and the MDS Nurse were to coordinate and ensure the meetings were completed as required.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §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 record review, staff, Resident and Physician interviews the facility failed to provide supervision to prevent a severely cognitively impaired Resident (Resident #151) from wandering into another Resident's room (Resident #41) resulting in an altercation and Resident #151 sustaining a right humeral (upper arm bone) fracture. This was for 1 of 2 Residents reviewed for supervision to prevent accidents. The findings included: Resident #151 was admitted to the facility on 11/5/21 with diagnoses that included history of seizures, stroke like episode, and psychosis. The Minimum Data Set (MDS) dated 12/14/21 indicated Resident #151 was severely cognitively impaired. There were no behaviors, verbal or physical, noted toward others in the 7 day assessment period of the MDS. Resident #151 wandered on 1 to 3 days and ambulated to and	F 689	F-689 1. Facility failed to provide supervision to resident #151 whom was severely cognitively impaired which resulted in him wandering into resident #41 room. This led to an altercation between the two residents resulting in resident #151 sustaining a right humeral (upper arm bone) fracture. Resident #151 discharged to home on 2/28/22. 2. On 4/1/22 an audit was conducted by the Social Worker to identify residents that have the potential to wander into other residents□ rooms. 3. Social Worker and Activity Director had a meeting with the alert and oriented residents to provide education on redirection and notifying staff if a cognitively impaired resident wanders into	4/8/22

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F 689	Continued From page 10 from areas outside of his room with the assistance of 1 staff member. A Physician Encounter Summary dated for 12/15/21 revealed Resident #151 was seen for agitation and psychosis. The facility Physician gave an order for Clonazepam (antianxiety) 1milligrams (mg) 3 times daily and Olanzapine (antipsychotic medication) 10mg at bedtime to treat. A progress noted dated 12/26/21 written by Nurse #3 revealed Resident #151 was out of his room ambulating down the facility hallways during the 7am-7pm shift. Staff was successful at times with redirection. A 24 Hour Initial Allegation Report dated 12/27/21 revealed that on 12/26/21 at 9:45pm Resident #151 attempted to enter the room of Resident #41. Resident #41 made him aware he was not to enter his room. Resident #151 struck Resident #41 in the face. Resident #41 put his hand up and pushed Resident #151 to the ground in attempt to stop any further altercation. Both Residents fell to the floor. The hall Nurse heard the altercation but was unsuccessful in reaching the Residents in time. She assessed both Residents for injuries. Resident #41 complained of some pain but declined any medical attention and Resident #151 had no complaints of pain when assessed on 12/26/21 following the incident. The MDS dated 10/23/21 indicated Resident #41 was cognitively intact. An interview was completed on 3/15/22 at 10:05am with Resident #41. He indicated the evening of 12/26/22 he was sitting in his wheelchair in the doorway of his room. He saw	F 689	their space and the abuse policy on 04/07/2022. Staff were provided education on strategies to redirect residents that wander starting on 04/05/2022. Newly hired facility staff and agency staff will receive education prior to working as part of the orientation process. 4. Effective 4/8/22, the Administrator or Social Worker will complete abuse questionnaires with 5 random staff members to ask if they have witnessed or heard of any abuse allegations. Abuse reportable will be reviewed to ensure timely reporting of abuse allegations to the Administrator. Monitoring will be completed one time a week for 4 weeks and then one time a month for two months as needed to ensure compliance. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with Abuse reporting.	

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Resident #151 walking up the hallway. He arrived at Resident #41's doorway and attempted to enter his room. Resident #41 stated when he told Resident #151 that wasn't his room and leave, Resident #151 hit him on the side of the face. Resident #41 stated he put his right hand out to protect himself from Resident #151 and ended up pushing him on his right shoulder. Resident #41 continued to state at that point his wheelchair rolled out from under him and he sat down on the floor and Resident #151 fell forward. He indicated he was not hurt in the altercation and refused any x-rays or further assessments.

A telephone interview was completed on 3/15/22 at 3:10pm with Nurse #5. She indicated she was coming down the hallway at approximately 9:45pm on 12/26/21 and heard Resident #41 yelling. She went towards his room to investigate and at that point she saw both Residents (Residents #151 and #41) in the doorway of Resident #41's room. Nurse #5 indicated Resident #151 proceeded to strike Resident #41 on the side of the face with his closed hand. She continued to state Resident #41's wheelchair rolled out from under him, and he sat down on the floor and Resident #151 became unsteady and fell on his stomach. Nurse #5 indicated he did not hit his head, nor complain of pain after the fall. She stated she attempted to get to Resident #151 to redirect him before he acted out but was not fast enough. Nurse #5 stated Resident #151 had no complaints of pain after the fall. She escorted him back to his room and assisted him into a reclining chair to rest. She stated she notified the Residents' responsible parties, the former Director of Nursing, and the Physician. She was instructed to observe the Residents the rest of the shift. Nurse #5 indicated during the rest of her

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shift Resident #151 rested in the reclining chair in her line of vision. She also stated she had never witnessed Resident #151 being violent towards Residents. Nurse #5 stated prior to evening of 12/26/21 Resident #151 would ambulate short distances down the hallways and she would keep an eye on him and redirect if he attempted to go in other Residents' rooms. She also stated Resident #41 normally stayed in his room unless he was going out to smoke. Nurse #5 stated Resident #41 normally didn't talk to other Residents.

A telephone interview was completed on 3/16/22 at 1:10pm with Nursing Assistant (NA) #6. She indicated she was working at the facility on 12/26/21 on the 7pm-7am shift but was unable to remember what Resident care assignment she had that shift. She stated she did not witness the exchange between Resident #41 and Resident #151 but did see Nurse #5 assisting the Residents after the event. She continued to state Resident #151 stayed in the reclining chair and bed the rest of the night within eyesight of a staff member. She further indicated she had never witnessed Resident #151 be aggressive towards staff or Residents. She stated prior to 12/26/21, Resident #151 was unsteady with walking and only able to walk a short distance. NA #6 continued to state she would use redirection attempts when he was wandering the hallway at night. She stated she had never witnessed Resident #151 go into other Residents' rooms.

A progress note dated 12/27/21 written by Nurse #7 stated when she arrived for her 7am shift she assessed Resident #151 and noted he had swelling, bruising, and pain to his right upper arm. The note further stated he had suffered a fall on

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the night of 12/26/21. The Physician was contacted and made aware of the new onset of symptoms and an order was received for a mobile x-ray of the right arm.

Emergency room notes dated 12/27/21 indicated Resident #151 was seen for a right humeral (upper arm bone) fracture. During the hospital stay, the Resident had no complaints of pain in his arm. A splint was applied to the right arm and Resident #151 was discharged back to the facility 12/27/21. A telephone interview was completed on 3/16/22 at 10:25am with Nurse #7. She indicated she worked with Resident #151 on 12/27/21for the 7am-7pm shift. She stated when she assessed the Resident he was complaining of pain in his right arm. Upon assessment, she stated she noticed swelling and bruising to the upper arm area. Nurse #7 stated she contacted the Physician and received an order for an in-facility x-ray. Nurse #7 stated the x-ray came back positive for a fracture of the right humerus bone, and she received an order from the Physician to send the Resident to the hospital for treatment. She further stated once Resident #151 returned to the facility he was always within eyesight of a staff member. Nurse #7 stated the Resident mainly stayed in the reclining chair or in bed, but when he came out of his room into the dining area or common area he was in the eyesight of staff. Nurse #7 further stated she had never witnessed Resident #151 exhibiting signs of aggressiveness towards Residents.

A telephone interview was completed on 3/16/22 at 11:52am with Nurse #6. She indicated she was very familiar with Resident #151. Nurse #6 stated she had never witnessed the Resident exhibit any signs of aggressive behaviors towards staff or

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F 689	Continued From page 14	F 689		

Residents. She stated he was confused at times and had to be reoriented to time and place. She stated prior to the 12/26/21 incident, Resident #151 would walk and wander short distances down the hallways and attempted to go in other Residents' rooms. Nurse #6 stated when this happened, she walked along with him, redirected him with a snack or something to drink and assist him back to bed. She indicated he normally slept the remainder of her shift after this.

An interview was completed with the Administrator on 3/15/22 at 9:30am. She indicated when she was made aware of the incident on 12/27/21, she immediately made sure staff were making sure Resident #151 was able to be viewed by a staff member when he was out of his room. She indicated this was passed on at each Nursing report. She stated she started having staff sign off on a 15 minute safety log on 12/30/21-1/8/22. She stated the Resident was no longer walking at that time, so she felt comfortable discontinuing the checks. The Administrator indicated there were no other incidents.

An interview was completed on 3/15/22 at 10:05am with the facility Physician. He indicated he was notified of the altercation between Resident #151 and Resident #41. He stated he felt the facility had no indication Resident #151 would have acted out towards another Resident in the manner he did. The Physician stated due to Resident #151's extensive medical history that included poor nutrition and history of a stroke led to brittle bones and any fall could have led to a fracture. He stated he felt the facility did everything possible to keep Residents safe.

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F 690	Continued From page 15	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		4/8/22

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F 690	Continued From page 16 Based on observation, record review and staff interview, the facility failed to obtain and include physician orders in the medical record for 1 of 2 sampled residents (Resident #103) with indwelling urinary catheters. The findings included: Resident #103 was admitted to the facility on 2/2/22 with diagnoses that included chronic kidney disease with urinary outlet obstruction and type 2 diabetes mellitus with other kidney complication. Resident #103's admission minimum data set (MDS) assessment dated 2/23/22 revealed the resident had moderate cognitive impairment. He had an indwelling catheter. A review of the 2/2/22 hospital discharge summary revealed Resident #103 had an indwelling urinary catheter. An observation of Resident #103 was conducted on 3/14/22 at 9:43 AM. Resident #103 had an indwelling urinary catheter. A review of Resident #103's physician's orders did not reveal an order for an indwelling urinary catheter. An interview conducted with the Wound Nurse on 3/16/22 at 10:40 AM. The Wound Nurse stated that the admitting nurse was responsible for ensuring there was an order for the catheter. On 3/17/21 at 11:30 AM an interview was conducted with Nurse #4. Nurse #4 stated it was important to have a physician's order for a catheter so that the facility knew the size of the	F 690	F690 1. Resident # 103 order was placed for the indwelling urinary catheter by Director of Nursing 03/18/22. 2. All residents with indwelling urinary catheters orders were audited to ensure the residents had the appropriate orders in their medical record by the Director of Nursing. No further residents were identified. 3. The Director of Nursing and Assistant Director of Nursing provided education to all facility licensed nurses on ensuring all residents with indwelling urinary catheters had orders from the attending physician. All new admission orders will be reviewed in the morning clinical meeting to ensure catheter orders are in place, if applicable. 4.The Director of Nursing or Assistance Director of Nursing will complete monitoring of three (3) residents one (1) time a week for four (4) weeks, weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance.	

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F 690	Continued From page 17 catheter and balloon. Nurse #4 stated that the resident had a to have a diagnosis that justified them having a catheter. An interview was conducted with the Regional Director of Clinical Services on 3/17/22 at 3:35 PM. The Director of Clinical Services stated that she expected there would be orders for the urinary catheter.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interviews, the facility failed to obtain a physician order for the use of supplemental oxygen for 1 of 2 residents reviewed for oxygen. (Resident #3). Findings included: Resident #3 was admitted to the facility on 10/10/14 with diagnoses which included acute and chronic respiratory failure with hypoxia. Record review of Resident #3 ' s Minimum Data Set (MDS) Quarterly Assessment dated 12/9/21 revealed he had severe cognitive impairment.	F 695	F 695 1. Resident #3 oxygen was removed after close observation of his oxygen saturations and consultation with the attending physician by the Director of Nursing on 3/16/22. 2. A review of all residents with oxygen were monitored for appropriate order transcription in the Electronic Medical Records (EMR). 3. The Director of Nursing and/or Assistant Director of Nursing provided	4/8/22

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F 695	Continued From page 18 Record review of physician orders revealed Resident #3 did not have an order for supplemental oxygen. An observation on 3/14/22 at 10:49 AM Resident #3 had oxygen via nasal canula (NC) at 3 liters per minute in place. An observation on 3/15/22 at 8:24 AM Resident #3 had oxygen via NC at 3 liters per minute in place. During an interview on 3/15/22 at 2:59 PM Nurse #3 revealed that a physician order was required for oxygen. She stated nursing was required to enter the physician order in the electronic medical record. Nurse #3 reported that Resident #3 was on oxygen but was not able to state why a physician order was not in place. During an interview on 3/16/22 at 12:41 PM the Physician revealed he was aware Resident #3 was on oxygen, but the order may have slipped through the cracks. During an interview on 3/17/22 at 2:34 PM the Director of Nursing revealed she was aware Resident #3 used oxygen. She stated a physician order was required for oxygen but was unable to state why an order was not obtained. During an interview on 3/17/22 at 2:45 PM the Clinical Regional Nurse revealed the nursing department was expected to maintain and follow physician orders for supplemental oxygen. During an interview on 3/17/22 at 4:33 PM the Administrator stated nursing was responsible to	F 695	education to all licensed nurses that residents on oxygen therapy must have an order for oxygen usage transcribed in EMR. 4. The Director of Nursing or designee will complete monitoring of three (3) residents one (1) time a week for four (4) weeks, weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance.	

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F 695	Continued From page 19 obtain physician orders and ensure they were entered in the electronic medical record.	F 695		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule an Registered Nurse (RN) for at least 8 consecutive hours per day for 6 of 76 days reviewed for sufficient staffing. (1/29/22, 1/30/22, 2/26/22, 2/27/22, 3/12/22, and 3/13/22). Findings included: A record review of the facility ' s Daily Staffing Sheet was conducted on 3/17/22. The Daily Staffing Sheets revealed the facility had not scheduled an RN for at least 8 consecutive hours a day on 1/29/22, 1/30/22, 2/26/22, 2/27/22, 3/12/22, and 3/13/22. During an interview on 3/17/22 at 12:58 PM the	F 727	F 727 The facility failed to provide registered nurse coverage for 8 consecutive hours a day for 6 out of 76 days reviewed. This cannot be retroactively corrected. Administrator, Director of Nursing and Staffing Coordinator/Staffing Coordinator reviewed the schedule effective 3/17/22 for that day and the following day to ensure there were at least 8 consecutive hours a day for 7 days a week of a Registered Nurse (RN) coverage. The Administrator reeducated the Staffing Coordinator/Scheduler and Director of	4/8/22

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F 727	Continued From page 20 Scheduler confirmed there was not an RN in the facility for at least 8 consecutive hours on 1/29/22, 1/30/22, 2/26/22, 2/27/22, 3/12/22, and 3/13/22. She revealed the facility was required to have an RN scheduled every day for a minimum of 8 hours, but she was unable to find RN coverage for those dates. She stated she was unable to remember if she notified the Director of Nursing (DON) or Administrator that the facility did not have an RN scheduled for those days. During an interview on 3/17/22 at 1:30 PM the Administrator revealed the DON and the Scheduler were expected to meet and review staffing. She stated she was not aware the facility was without RN coverage for at least 8 consecutive hours on those days. During an interview on 3/17/22 at 2:42 PM the DON stated she did meet with the Scheduler and review staffing but stated she was a new hire in February. She sated she was unable to comment on the dates 1/29/22 and 1/30/22 but stated she was not aware there was not an RN scheduled for at least 8 consecutive hours on 2/26/22, 2/27/22, 3/12/22, and 3/13/22.	F 727	Nursing on the requirement for consecutive 8-hour registered nurse coverage in the facility daily on 4/1/21. The Director of Nursing or designee will review the daily staffing schedule to ensure consecutive 8 hour Registered Nurse Coverage is in place at the morning meeting. Daily staffing postings will be brought to the monthly Quality Assurance Performance Improvement meeting x 3 months for review and need for ongoing monitoring by the DON.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		4/8/22

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F 758	Continued From page 21 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AND REHABILITATION	38 CARTERS ROAD GATESVILLE, NC 27938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 22 Based on record review, staff, Physician, and Pharmacy Consultant interviews, the facility failed to have a stop date for Ativan (medication used for anxiety) as needed (PRN) for 1 of 6 residents reviewed for unnecessary medication. (Resident #18). Findings included: Resident #18 was admitted to the facility on 6/18/21 with diagnoses which included anxiety, major depressive disorder, and intermittent explosive disorder. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 1/10/22 Resident #18 was coded for use of antianxiety medication. A physician order dated 2/23/22 for Ativan 0.5 milligram (mg) tablet every 12 hours as needed for anxiety without a stop date. During an interview on 3/16/22 at 12:47 PM the Physician stated he usually puts a stop date but may have missed it. During a telephone interview on 3/17/22 at 1:51 PM the Pharmacy Consultant revealed the Ativan PRN order required a stop date. He stated the monthly pharmacy review for February orders was completed prior to the order date. During an interview on 3/17/22 at 2:34 PM the Director of Nursing stated she entered the order without a stop date because a stop date was not given. She was not aware it required a stop date. During an interview on 3/17/22 at 2:47 PM the Corporate Regional Nurse stated nursing was	F 758	F758 1.Resident #38 Ativan order was discontinued and reordered to reflect a 14 day stop date for the PRN psychotropic. 2. All residents with PRN psychotropic medication orders have the potential to be affected. All residents with PRN psychotropic medications orders were reviewed by the Director of Nursing for the appropriate stop date. 3. The Director of Nursing educated licensed nursing staff on obtaining an order for a 14-day stop date for all PRN psychotropic medications. Director of Nursing will review residents with PRN psychotropic medication for compliance during morning clinical meeting. 4. The Director of Nursing or Designee will audit five (5) residents weekly then once (1) a month for three (3) months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance.	

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F 758	Continued From page 23 responsible to monitor and ensure stop dates were in place. During an interview on 3/17/22 at 4:33 PM the Administrator stated nursing was required to make sure all physician orders were entered correctly.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to prevent a significant medication error by not following a physician's order to administer an anticoagulant for 1 of 2 residents reviewed for anticoagulation therapy (Resident #106). The finding included: Resident #106 was admitted to the facility on 3/10/22 with diagnoses that included atrial fibrillation. A review of the hospital discharge summary dated 3/10/22 revealed an order for Eliquis (a medication to prevent the blood from clotting) 10 mg by mouth one time daily. Review of a physician's order dated 3/10/22 revealed Resident 106 was to receive Eliquis 2.5 milligrams (mg) one tablet two times daily. The order was in confirmation pending status on the electronic medication administration record (EMAR). This meant that the order was not	F 760	F-760 1. Resident #106 began receiving her Eliquis on 3/15/22. 2. All residents in the facility have the potential to be affected; therefore, an initial facility wide audit of all current resident medication orders for availability in the medication cart was conducted. Audit was conducted by the Assistant Director of Nursing and completed 4/1/22. 3. The Director of Nursing educated all licensed nursing staff on the facility policy and procedure related to medication availability, ordering, reordering, and receiving to ensure medication administration as prescribed by the physician to prevent medication errors. Education included process of receiving nurse signing pharmacy delivery tickets, placing copy in the Director of Nursing	4/8/22

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F 760	Continued From page 24 showing up on the EMAR for nursing to give the medication. A review of Resident #106's MAR for March 2022 revealed that Eliquis was not administered as ordered on the following dates: -3/10/22 -3/11/22 -3/12/22 -3/13/22 -3/14/22 A review of the admission Minimum Data Set (MDS) assessment dated 3/17/22 revealed Resident #106 was cognitively intact and received an anticoagulant 3 days of the look back period. An interview was conducted with the Wound Nurse on 3/14/22 at 3:13 PM. The nurse stated that all admission orders were entered by the admitting nurse. The nurse stated new orders were to be reviewed in the daily morning clinical meeting. The nurse stated that Resident #106's orders had not been reviewed in the clinical morning meeting. The morning clinical meeting had not been occurring consistently. An interview was conducted with Nurse #4 on 3/14/22 at 10:27 AM. Nurse #4 stated that Eliquis did not show on the electronic medication administration record for her to administer. Nurse #4 was assigned to the resident and the MAR was reviewed with her. Eliquis 2.5 mg did not appear in the EMAR for administration. The Eliquis 2.5 mg order was listed under the orders pending status on the orders page of the EMAR. Nurse #4 stated that the nurse should check the EMAR for pending orders and accept them.	F 760	mailbox, placing medication on medication cart and confirming receipt in the Electronic Medication Record (EMR). Education on notification to the attending physician if medication is not available or administered as ordered for follow-up as indicated. The Director of Nursing will review delivery tickets and pharmacy alerts on the EMR order dashboard and follow-up as needed to ensure medication delivery and availability. The Director of Nursing will review the Electronic Medication Administration Record (EMAR) during morning clinical meeting to ensure compliance with administration for previous 24-hours and provide follow-up as necessary to ensure residents are free from significant medication errors. 4. Assistant Director of Nursing or designee will conduct random audits of five (5) resident medication orders for availability and administration per the EMAR as ordered. Monitoring will be completed for five residents weekly for three months then five residents monthly for three months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance.	

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F 760	Continued From page 25 An interview was conducted with Resident #106's primary care physician on 3/16/22 at 12:41 PM. The physician stated that he had been made aware that Resident #106 had missed doses of Eliquis. He stated that labs were ordered, and the medication order was updated. The physician stated he had assessed Resident #106 on 3/16/22 and there was no negative outcome. An interview was conducted with the Corporate Clinical Nurse Consultant on 3/17/22 at 3:40 PM. The Nurse Consultant stated that she expected the orders would be confirmed during medication pass and the nurse would notify the Director of Nursing if there was a concern.	F 760		