STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 onsite recertification and complaint survey was conducted on 4/25/22 through 4/27/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # E1Z211.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted 4/25/22 through 4/27/22 (Event ID #E1Z211). A total of 1 allegation was investigated and it was unsubstantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Hospice (Resident #37 and Resident #19). This was for 2 of 3 resident MDS assessments reviewed for Hospice. Findings included: 1. Resident #37 was admitted to the facility on 2/29/16 with diagnosis which included non-Alzheimer's dementia and diabetes mellitus. Resident #37's significant change Minimum Data Set (MDS) dated 03/03/22 revealed she was severely cognitively impaired requiring extensive assistance of two staff members for most	F 641	1. The facility failed to correctly code Minimum Data Set (MDS) assessments in the area of Hospice care for Resident # 37 and Resident # 19, 2 of 3 residents reviewed for MDS accuracy. MDS corrections were initiated for resident # 37 and resident # 19 on 4/27/2022 and completed by MDS Nurse. 2. Residents currently admitted to the facility under hospice care are at risk to be affected by the deficient practice. The MDS Nurse and Regional MDS Nurse completed an audit of MDS assessments completed on residents under hospice care, reviewing the care area of hospice that were completed and submitted from	5/18/22

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

Electronically Signed | 05/19/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 641	Continued From page 1 activities of daily living (ADL). Resident #37 was not coded for Hospice. A progress note dated 03/03/22 revealed Resident #37's family had requested the resident be transitioned into full Hospice care. A new order was received from the Physician for Resident #37 to be under Hospice care on this date. An interview conducted on 04/27/22 at 9:04 AM with MDS Nurse #1 revealed Resident #37 was transitioned into Hospice care on 03/03/22 and a significant change MDS was completed for Hospice on that date. She stated Resident #37 was not coded on the MDS for Hospice care by mistake because that was the reason the MDS was completed. The interview revealed an outside source had completed the MDS to assist the facility and had coded the MDS in error. On 04/27/2022 at 2:19 PM an interview with the Director of Nursing (DON) indicated Resident #37's MDS assessment should be an accurate reflection of her status. 2. Resident #19 was admitted to the facility on 1/21/19 with diagnosis which included non-Alzheimer's dementia. Review of a Physician order dated 06/02/21 revealed Resident #19 was admitted under Hospice services. Resident #19's most recent quarterly Minimum Data Set (MDS) dated 02/24/22 revealed she was severely cognitively impaired requiring extensive assistance of two staff members for most activities of daily living (ADL). Resident #19 was not coded for Hospice.	F 641	4/01/2022 through 5/01/2022. Audit completed to identify inaccurately coded assessments and issues identified will be corrected and MDS assessments will be resubmitted by 4/27/2022. Audit findings identified 2 incorrect assessments, with corrections submitted on 4/27/2022. 3. The following measures have been put into place to ensure the deficient practice does not recur are, Facility MDS nurse(s) will be re-educated by the Regional MDS nurse on MDS assessment care areas pertaining to hospice. Education was completed by 4/27/2022. Newly hired MDS nurses will be educated upon hire. 4. The Director of Nursing or designee will complete an audit of MDS Assessment care area of hospice weekly for four (4) weeks, then bi-weekly for eight (8) weeks to ensure accuracy. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee monthly. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with comprehensive assessments and timing. 5. Completion Date: 5/18/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 641	Continued From page 2 An interview conducted on 04/27/22 at 9:04 AM with MDS Nurse #1 revealed Resident #19 was had been on Hospice care since 06/02/21. She stated Resident #19 was not coded on the MDS for Hospice care and should have been. The interview revealed an outside source had completed the MDS to assist the facility and had coded the MDS in error. On 04/27/2022 at 2:19 PM an interview with the Director of Nursing (DON) indicated Resident #19's MDS assessment should be an accurate reflection of her status.	F 641		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		5/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 693	Continued From page 3 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview, and staff interviews the facility failed to provide a tube feeding as ordered by the physician for 1 of 2 residents (Resident #6). The findings included: Resident #6 was admitted to the facility on 7/18/21 with diagnoses that included aphasia, stroke, hemiplegia, and cerebral infarction. A physician order dated 12/23/21 read, Jevity (enteral feeding) 1.2 per tube via G-Tube at 80 milliliters (ml) per hour (hr) continuously for 15 hours starting at 4 PM and to end at 7 AM. The quarterly Minimum Data Set (MDS) dated 1/21/22 indicated Resident #6 was cognitively intact for daily decision making and was extensive to total assistance with activities of daily living (ADL). The MDS further indicated that Resident #6 had a feeding tube and received 51% or more of her daily calories via G-Tube. No weight gain or loss was noted during the observation period. The MDS revealed Resident #6 was coded for no speech. An observation and interview were conducted with Resident #6 on 4/26/22 at 2:00 PM revealed Resident #6's tube feeding was running at 80 ml and Resident #6 was signaling for the tube feeding to be turned off. Resident #6 was unable to speak and had a note pad and pen available but did not want to use it to communicate. Resident #6 nodded yes that the tube feeding	F 693	1. Facility failed to provide tube feeding as ordered by the physician for 1 of 2 residents. Resident #6 received tube feeding during the day when not ordered. Nurse # 1 was immediately re-educated on Tube Feeding Orders by Director of Nursing (DON), and Nurse Practitioner (NP) was notified. Tube feeding on Resident # 6 was stopped by Nurse #1 immediately upon notification. Resident # 6 was assessed by nursing with no issues identified. Tube feeding orders were adjusted by NP to ensure resident received appropriate calorie intake for 24-hour period. Registered Dietician was also notified on 4/26/2022. 2. Current facility residents receiving tube feeding are at risk of being affected by the deficient practice. DON and Quality Assurance (QA) nurse completed an audit of orders for current residents receiving tube feeding and reviewed batch order set for enteral feeding in electronic health record. No other areas of concern identified. 3. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: All facility and agency licensed nurses will be re-educated on Feeding Tube Orders. Feeding tube orders are clarified in electronic health record to show a specific	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 693	Continued From page 4 was turned on this morning and had been running. It was observed the label on the tube and bag dated 4/26/22 at 3:45 AM and only an estimated two inches of content was left the bag. An interview conducted with Nurse #1 on 4/26/22 at 2:10 PM revealed she started her shift at 7 AM and Resident #6's tube feeding was turned off. Nurse #1 further revealed approximately 11:00 Am to 11:30 AM she turned Resident #6's tube feeding on and did not look at the resident's order. Nurse #2 observed Resident #6's tube feeding order and stated the order read for Resident #6's tube feedings to run from 4 PM to 7 AM. Nurse #2 indicated she should have reviewed Resident #6's orders before turning on the tube feeding, and would turn off Resident #6's feed tubing immediately. An interview conducted with the Director of Nursing (DON) on 4/26/22 at 2:17 PM revealed she was not aware Resident #6's tube feeding was running. The DON pulled up Resident #6's orders and read Resident #6's tube feeding was ordered to run from 4 PM to 7 AM. The DON stated she would advise Nurse #1 to stop Resident #6's tube feeding and would contact the Nurse Practitioner (NP). The DON indicated it was expected for staff to read orders and follow them as ordered. An interview conducted with Nurse #2 on 4/26/22 at 3:45 PM confirmed she had worked third shift on 4/25/22 at 7 PM until 4/26/22 at 7 AM. Nurse #2 revealed Resident #6's tube feeding had run out at 3:45 AM and a new tube and bag was hung. Nurse #2 indicated at 7 AM she had turned off the tube feeding and left the facility.	F 693	start and stop time that must be signed off by nurse for administration of Tube Feeding. Director of Nursing and Quality Assurance Nurse completed this education with facility and agency licensed nurses 4/29/22. Newly hired facility and agency licensed nurses will be educated upon hire and prior to working their first shift. 4. The Director of Nursing or designee will complete an audit of Tube Feeding Administration weekly for four (4) weeks, then bi-weekly for eight (8) weeks to ensure accuracy. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with tube feeding management. 5. Completion Date: 5/18/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 693	Continued From page 5 A phone interview conducted with the Nurse Practitioner (NP) on 4/26/22 at 4:00 PM revealed Resident #6 had received tube feeding during the day when not ordered. The NP further revealed she advised the facility to assess Resident #6's abdomen, listen to bowel sounds, and check the resident's residual. The NP indicated she did not believe Resident #6 would have any adverse side effects but would contact the facility to follow up. An interview conducted with Administrator at 4/26/22 at 6:00 PM she believed Resident #6's tube feeding had been turned on after morning medicines were given but expected for nursing staff to review and follow orders. A new order was obtained to start the next tube feeding on 4/26/22 from 11:45 PM to 7 AM. The Administrator revealed Resident #6 was assessed for bowel sounds, residual, and abdominal checks by a Nurse and no issues were identified.	F 693		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		5/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 880	Continued From page 6	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 880	Continued From page 7 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 1 of 3 staff members on the (Nurse Aide #1) failed to wear full Personal Protective Equipment (PPE) when entering a resident's room on enhanced droplet precautions (Resident #319). This failure occurred during a COVID-19 pandemic. The findings included: The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following statement under Section 2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: *HCP (Healthcare personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown,	F 880	1. Facility failed to ensure proper infection control practices were in place when a NA# 1 entered Resident # 319 room who was on Quarantine without donning proper personal protective equipment (PPE) to provide care for resident. NA# 1 was immediately re-educated on PPE Donning and Doffing, Isolation precaution signage, and adhering to precautions by the Director of Nursing (DON) and Administrator when they were made aware of the deficient practice 4/25/2022. 2. Current facility residents are at risk to be affected by the deficient practice. The DON and Unit Manager began education with current facility and agency staff on 4/25/2022 on PPE Donning and Doffing, Isolation precaution signage, and adhering to precautions. 3. The following measures have been put into place to ensure the deficient practice does not recur are as follows; current facility and agency staff will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 880	Continued From page 8 gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). The facility's policy entitled "Novel Coronavirus Prevention and Response" revised 02/02/22 indicated the following under "Policy Explanation and Compliance Guidelines: 5. Interventions to prevent the spread of respiratory germs within the facility: g. Promote easy and correct use of personal protective equipment (PPE) by: 1. Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. 2. Make PPE, including facemask, eye protections, gowns, and gloves available Immediately outside of the resident's room. 3. Position a trash can near the exit inside any resident room to make it easy to discard PPE. 8. Managing a resident who had close contact with someone with SARS-Co-V-2 infection a. Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-Co-V-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator)." Upon entry to the facility on 04/25/22 there were 3 residents quarantined with enhanced droplet contact precautions on the 500 hall. Resident #319 was quarantined due to not being fully	F 880	educated on PPE Donning and Doffing, Isolation precaution signage, and adhering to precautions. Education will be completed by DON or Quality Assurance (QA) Nurse. Newly hired facility and agency staff and facility and agency staff that did not complete education by 4/27/22, will complete education upon hire and prior to working. 4. The Administrator or designee will complete random audits five (5) times a week for four (4) weeks, then five (5) times bi-weekly for four (4) weeks, then five (5) times monthly for 2 months to ensure compliance. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with comprehensive assessments and timing. 5. Completion Date: 5/18/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 880	Continued From page 9	F 880		

vaccinated and being exposed to a staff member that tested positive for COVID-19. There was a sign on the door of Resident #319's room that read "Special Droplet Contact Precautions." The sign indicated that all healthcare personnel must: clean hands before entering and when leaving room, wear a gown when entering and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting, protective eyewear (face shield or goggles), wear gloves when entering room and remove before leaving and place in private room and keep door closed if safe to do so." There was a caddie on the outside of the door beside the sign with PPE supplies stocked in the caddie.

A continuous observation on 04/25/22 from 3:48 PM to 3:53 PM revealed NA #1 inside Resident #319's room assisting her while wearing just a surgical mask. Resident #319 was in the room sitting in her chair without a mask while NA #1 assisted her.

An interview on 04/25/22 at 3:54 PM with NA #1 revealed she had been going in and out of rooms on the 500 hall including quarantine rooms with just a surgical mask on her face. NA #1 stated no one had told her she needed to wear PPE in rooms 509, 510 and 511. NA #1 further stated she though the caddies on the doors of these rooms were for decoration and said she had not read the signs on the door. The sign on the outside of Resident #319's door was reviewed with NA #1 and she said again no one had told her she had to wear PPE when going in and out of rooms 509, 510 and 511.

An interview on 04/25/22 at 8:55 PM with the facility's Infection Preventionist revealed NA #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345083	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT RUTHERFORD LLC	188 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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 880	Continued From page 10 should have known to wear PPE in Resident #319's room and said she would be providing one-on-one education with NA #1 and education would be provided to all staff regarding the use of PPE for residents on special droplet contact precautions. An interview on 04/27/22 at 2:23 PM with the Director of Nursing (DON) revealed all staff had been educated on procedures for wearing PPE into resident rooms on special droplet contact precautions. The DON stated additionally, they had provided one-on-one education to NA #1 and all staff had been re-educated about proper use of PPE.	F 880		