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	345406	A. BUILDING _____ B. WING _____	C 08/14/2024

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 8/12/24 through 8/14/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# ZSDC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 8/12/24 through 8/14/24. Event ID# ZSDC11. The following intakes were investigated: NC00218809 and NC00219036. 9 of 9 complaint allegations did not result in deficiency.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		8/15/24

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

Electronically Signed | 09/04/2024

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.

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident

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F 585	Continued From page 2 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident and staff, the facility failed to ensure the resident's right to file a grievance and receive written notification of the decision regarding the grievance investigation for 4 of 5 residents reviewed for the grievance process. (Resident	F 585	1. On Thursday August 15, 2024 the facility administrator and the Interdisciplinary Team were able to discuss on the grievance process and ensuring that verbal and written resolutions were given to the residents	

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F 585	Continued From page 3 #17, Resident #9, Resident #22, and Resident #21) The findings included: Review of the facility policy dated 3/8/22 titled "Grievance Policy" read in part: 7. The facility must ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident ' s grievance, the steps taken to investigate the grievance, a summary of the pertinent finding or conclusions regarding the residents ' concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken by the facility, and the date the written decision was issued. 1. Resident #17 was admitted to the facility on 2/25/22. A review of the quarterly Minimum Data Set (MDS) dated 7/7/24 revealed Resident #17 was cognitively intact. Review of a grievance filed since the last standard survey on 5/11/23 revealed Resident #17 had filed a grievance on 8/16/23. The 8/16/23 grievance revealed Resident #17 expressed concerns about receiving pork despite her saying she does not eat pork. An interview was conducted with Resident #17 on 8/13/24 at 2:00 PM and she explained she had not received a written resolution regarding the outcomes of the grievance she had reported and had not been told verbally. Resident #17 reported that she still received pork on her meal tray.	F 585	that were affected and on August 15, 2024 which included Resident #17, Resident #9, Resident #22 and Resident #21. 2. Residents who are filing a grievance through the facility with a concern have been identified as having the potential to be affected. 3. The Nursing Home Administrator was able to educate all interdisciplinary team members on August 15, 2024 on making sure they are following the grievance process by providing a copy of the filed grievance to the resident along with a written resolution and offering for them to sign if they would like. Also, reminded facility Social Worker to make sure that she mails a copy of the grievance along with written resolution if family member is one who files grievance and provide documentation in residents chart by Social Worker on process that was completed from facility on resolution. 4. In the Quality Assurance and Performance Improvement Committee the facility Social Worker will bring to QAPI for the next three months to make sure that all residents are receiving a written resolution to the grievance being filed and told verbally also and that the process will continue to be followed through. 5. Date completed was 8/15/2024	

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During an interview with the Administrator on 8/14/24 at 10:56 AM he stated he was responsible for coordinating the grievance process. He indicated grievances were reviewed each morning with the interdisciplinary team during morning meetings. He stated the grievances were dispersed to the corresponding department and resolution completed within 72 hours. The Administrator further stated the grievances came back to the interdisciplinary team and were reviewed by the grievance officer. The grievance outcome was given to the person who filed the grievance in writing but was sometimes provided verbally. He revealed he told Resident #17 verbally of the grievance outcome.

2. Resident #9 was admitted to the facility on 1/13/23.

A review of the quarterly Minimum Data Set (MDS) dated 5/23/24 revealed Resident #9 was cognitively intact.

Review of the grievances filed since the last standard survey on 5/11/23 revealed Resident #9 had filed a grievance on 8/2/23. The 8/2/23 grievance revealed Resident #9 had an issue with her bed not being made.

An interview was conducted with Resident #9 on 8/13/24 at 2:22 PM and she explained she had not received a written resolution regarding the outcomes of the grievance she had reported and had not been told verbally.

During an interview with the Administrator on 8/14/24 at 10:56 AM he stated he was

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responsible for coordinating the grievance process. He indicated grievances were reviewed each morning with the interdisciplinary team during morning meetings. He stated the grievances were dispersed to the corresponding department and resolution completed within 72 hours. The Administrator further stated the grievances came back to the interdisciplinary team and were reviewed by the grievance officer. The grievance outcome was given to the person who filed the grievance in writing but was sometimes provided verbally. He revealed he told Resident #9 verbally of the grievance outcome.

3. Resident #22 was admitted to the facility on 1/22/21.

A review of the most recent annual MDS dated 7/14/24 revealed the resident was cognitively intact.

Review of the grievances filed since the last standard survey on 5/11/23 revealed Resident #22 had filed 8 grievances with the facility on 7/9/23, 9/25/23, 11/15/23, 12/7/23, 12/28/23, 1/3/24, 5/6/24, 5/8/24, 7/19/24. Review of the 7/9/23 grievance revealed Resident #22 complained of cold food. The 9/25/23 grievance expressed by Resident #22 was related to an argument with another resident in the dining room. The grievance shared on 11/15/23 was regarding the Administrator ' s action when delivering her groceries. Review of the grievance initiated on 12/7/23 revealed Resident #22 had a disagreement with another resident. The 12/28/23 grievance expressed by Resident #22 was related to a pair of missing pants and socks. The grievance shared on 1/3/24 was regarding dietary

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staff when Resident #22 asked for an alternate meal. Review of the grievance dated 5/6/24 revealed Resident #22 she was still missing pants and food. The 5/8/24 grievance expressed by Resident #22 was related to her not being able to open the door to her room while in the wheelchair, requesting another bedside table, and remove boxes from the floor. The grievance shared on 7/19/24 was regarding staff not putting creams and lotions on resident legs and not hanging up clothing.

An interview was conducted with Resident #22 on 8/12/24 at 11:40 AM and she explained she had not received a written resolution regarding the outcomes of the grievances she had reported and had not been told verbally.

During an interview with the Administrator on 8/14/24 at 10:56 AM he stated he was responsible for coordinating the grievance process. He indicated grievances were reviewed each morning with the interdisciplinary team during morning meetings. He stated the grievances were dispersed to the corresponding department and resolution completed within 72 hours. The Administrator further stated the grievances came back to the interdisciplinary team and were reviewed by the grievance officer. The grievance outcome was given to the person who filed the grievance in writing but was sometimes provided verbally. He revealed he told Resident #22 verbally of the grievance outcomes.

4. Resident #21 was admitted to the facility on 8/26/22.

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F 585	Continued From page 7 A review of the quarterly Minimum Data Set (MDS) dated 7/31/24 revealed the resident was cognitively intact. Review of a grievance filed since the last standard survey revealed Resident #21 had filed a grievance on 7/12/23. Review of the 7/12/23 grievance revealed Resident #21 had missing money. An interview was conducted with Resident #21 on 8/13/24 at 9:32 AM and she explained she had not received a written resolution regarding the outcomes of the grievances she had reported and had not been told verbally. During an interview with the Administrator on 8/14/24 at 10:56 AM he stated he was responsible for coordinating the grievance process. He indicated grievances were reviewed each morning with the interdisciplinary team during morning meetings. He stated the grievances were dispersed to the corresponding department and resolution completed within 72 hours. The Administrator further stated the grievances came back to the interdisciplinary team and were reviewed by the grievance officer. The grievance outcome was given to the person who filed the grievance in writing but was sometimes provided verbally. He revealed he told Resident #21 verbally of the grievance outcome.	F 585		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.	F 925		8/15/24

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F 925	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to maintain an effective pest control program as evidenced by the presence of flies on 2 of 5 Hallways that affected resident rooms 117, 118, 121, 122, and 123. The findings included: Review of the pest control receipt for 6/28/24 read: inspected and treated select areas with a focus on kitchen. Performed exterior rodent services, checked accessible bait stations and replaced bait as needed. No rodent or insect activity was noted during inspection and/or service. There was no mention of a fly program service. Review of the pest control receipt for 7/31/24 read: inspected and treated select areas. Performed exterior rodent services, checked accessible bait stations and replaced bait as needed. No rodent or insect activity was noted during inspection and/or service. There was no mention of a fly program service. a. An observation of a resident in Room 123 was conducted on 08/12/24 at 09:32 AM. There were flies noted in the room that landed on the bed, the bedside table and the resident ' s hand. b. An observation of a resident in Room 116 was conducted on 08/12/24 10:12 AM. There were flies noted in the room that landed on the bed, on the resident ' s leg and the bedside table. An observation of a resident in Room 116 was	F 925	1. On Thursday August 15, 2024 the facility Administrator was able to meet with Interdisciplinary Team to ensure facility is following pest control program for Room #117, Room #118, Room #121, Room #122, and Room #123 and were able to place insect lights into affected rooms on August 15, 2024 to ensure the control of flies. The facility was able to ensure that all indoor insect lights that are in hallways and other areas throughout the facility were working properly and door blowers that over certain doors within the facility when they open to prevent pests from coming into the facility. 2. Residents who reside within the facility are all affected by the pest control program, such as flies being throughout the facility, including resident rooms. 3. The facility was able to ensure that all indoor insect lights that are located in the hallways and other areas through out the facility are working properly and if not then they were replaced and the glue pad was also observed and if needed changed it was completed. The facility maintenance director will continue to ensure the glue boards are checked monthly and changed every three months or sooner if needed. The facility also was able to purchase additional indoor plug in insect lights for designated areas within facility and resident rooms that could continue to be affected. 4. As part of the facilities continuous Quality Assessment and Performance Improvement, the facility Maintenance	

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F 925	Continued From page 9 conducted on 8/14/24 at 10:36 AM. There were flies noted on the bedside table, on the cup of orange juice on the bedside table, and on the cup of coffee on the bedside table. An observation of a resident in Room 116 was conducted on 8/14/24 at 12:53 AM. There were flies in the room that landed on the bed, urinary drainage bag tubing and resident ' s foot. c. An observation of a resident in Room 121 was conducted on 08/12/24 at 10:50 AM. There were flies noted in the room that landed on the bed, on the resident ' s lap and the bedside table. The resident stated he had issues with flies and had purchased a fly swatter which he was holding. d. An observation of a resident in Room 122 was conducted on 08/12/24 11:08 AM. There were flies noted in the room that landed on the bed and the bedside table. e. An observation was conducted on 08/12/24 at 02:15 PM. There were flies in the room, on the resident ' s chest and on the arm rest of the wheelchair the resident was sitting in. An observation was conducted on 08/13/24 at 10:55 AM. There were flies noted in the room on the resident 's chest and the resident's bed. An interview was conducted with NA #1 on 8/12/24 at 2:40 PM. NA #1 stated she was a full-time employee at the facility and worked on the hallway where rooms 116, 117, 121 were located. NA #1 stated that there were insect lights on the wall in the hallway and a door blower over the exit door to help with flies.	F 925	Director will perform weekly rounds for four months to rooms that have insect lights plugged in resident rooms are working properly and being monitored and effective and change when needed. 5. Date completed was on 8/15/2024	

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During a resident council meeting held on 8/13/24 at 2:00 PM, the council reported that they had been having issues with flies and had mentioned it to the Administrator.

An interview was conducted with the Maintenance Director on 8/14/24 at 9:13 AM. The Maintenance Director stated that the Pest Control Technician comes to the facility once a month. The Maintenance Director stated he provided the fly program service and the number of flies in the facility depended on the weather. He explained that the facility had insect lights on the hallway walls and door blowers over the C Hall (Rooms 114 to 121) and D Hall (Rooms 122 -126) exit doors. The D Hall exit door lead out to the smoking gazebo which resident entered and exited multiple times each day. The Maintenance Director stated the glue boards in the insect lights were checked every month and changed every three months or sooner if needed. The Maintenance Director stated he sprays fly spray around the outside of the kitchen back door and the outside exit doors daily but is unable to use the fly spray inside the facility due to some residents being sensitive to the chemicals.

The Administrator was interviewed on 8/14/24 at 10:56 AM. The Administrator stated the Pest Control Technician comes to the facility once a month to inspect and treat selected areas of the facility. The Administrator stated he felt that the facility had insect lights and door blowers to help with the flies. The Administrator stated the Maintenance Director was responsible for the maintenance of the hallway insect lights and he was unaware of any issues with the equipment.