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 _____	01/31/2019

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 survey was conducted on 01/29/19 through 01/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DUP511.	E 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		2/20/19

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

Electronically Signed | 02/20/2019

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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F 623	Continued From page 1	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 2 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the responsible person in writing of the reason a resident was discharged to the hospital for 1 of 1 residents reviewed for hospitalization. (Resident # 11). The findings included: Resident #11 was originally admitted to the facility on 4/11/16 with diagnoses including Hypertension, Cerebral Infarction and Atrial Fibrillation. According to the most recent Quarterly Minimum Data Set dated 7/29/18,	F 623	1. Resident #11 was discharged to the hospital on 9/22/18-10/1/18 and again on 10/18/18-10/23/18 with bed hold policy notification. Resident #11 returned prior to survey and therefore no notice was sent to responsible person. 2. No current residents are currently discharged to the hospital or therapeutic leave. 3. Social worker was re-educated by the administrator on 2/15/19 on the process of sending a discharge letter to the responsible person when a resident is	

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F 623	Continued From page 3 Resident #11's cognition was severely impaired. Review of Resident #11's medical record revealed he was discharged to the hospital on 9/22/18 and was readmitted to the facility on 10/1/18. The resident was also discharged to the hospital on 10/18/18 and was readmitted to the facility on 10/23/18. During an interview on 1/30/19 at 2:00 PM, Staff Nurse #1 revealed Resident # 11's responsible person would have been notified by telephone, however, she did not know if a written notification was sent to the responsible person. During an interview on 1/30/19 at 2:30 PM, the Director of Nursing revealed the nurses notified the family as soon as transportation took place to the hospital but they did not send written notification to the responsible person when a resident was discharged to the hospital. During an interview on 1/30/19 at 3:20 PM, the facility Social Worker revealed the nurse usually called the responsible person to let them know when a resident was discharged to the hospital. She said she was not aware of written notification being sent to the responsible person regarding a resident's discharge to the hospital. During an interview on 1/31/19 at 3:12 PM, the Administrator revealed her expectation would be for written notification to be sent to the responsible person when a resident was discharged to the hospital.	F 623	discharged to the hospital. The Social worker will mail a letter to the responsible person when a resident is discharged to the hospital and a copy of the letter will be placed in the resident's medical record. 4. The DON will audit all discharges to the hospital monthly for 3 months to ensure the responsible person is sent a letter. 5. The Social worker will present the results of the visual audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure compliance.	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)	F 661		2/20/19

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F 661	Continued From page 4 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 residents reviewed for a planned discharge to another facility. (Resident #58) The findings included: Resident #58 was originally admitted to the facility on 10/22/18. According to the most recent	F 661	1. Resident #58 was discharged on 11/19/18 2. Residents discharged as of January 31,2019 have a recapitulation of their stay in the medical record 3. Each interdisciplinary team member (IDT) was re-educated by the administrator and DON on 2/15/19 on how to complete the recapitulation of a	

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F 661	Continued From page 5 minimum data set (MDS) (discharge return not anticipated) dated 11/19/18, Resident #58 was cognitively impaired. Resident #58's expectation was to be discharged to another facility. Resident #58 was discharged to another facility on 11/19/18 and a review of the closed record revealed the facility failed to complete a recapitulation of the resident's stay. During an interview on 1/30/19 at 3:25 PM, the facility Social Worker revealed discharge was discussed in Resident #58's care plan meeting. She said Resident #58 was discharged to another facility. She stated she did not know if the nurses completed the recapitulation of stay. During an interview on 1/31/19 at 10:31 AM the Director of Nursing (DON) revealed the facility physician saw Resident #58 and he completed a discharge summary. Review of the facility physician's progress note dated revealed it was not a discharge summary which included all the components of the recapitulation of stay and a final summary of the resident's status at discharge. During an interview on 1/31/19 at 1:40 PM, the MDS Coordinator revealed Resident #58 was sent to an adult living facility in another city. She revealed Resident #58's discharge was set up while he was in the hospital and the Social Worker or Nursing would be responsible for doing the discharge summary. She revealed she was just responsible for completing the MDS. Interviews with some members of the interdisciplinary team revealed no one was	F 661	residents stay using the user defined assessment in the computer. 4. The Social Worker will audit all discharges to the community or other facilities monthly for 3 months to ensure the recapitulation of a resident's stay is completed. 5. The Social worker will present the results of the visual audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure compliance	

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F 661	Continued From page 6 familiar with the recapitulation of stay or who was responsible for completing the summary. During an interview on 1/31/19 at 3:14 PM the Administrator revealed they did not start Resident #58's discharge process because the discharge was already being done before the resident arrived at the facility. She revealed Resident #58 was a special case and required skilled nursing care prior to his discharge to an adult living facility. She revealed her expectation was to ensure staff completed a discharge summary with a recapitulation of stay upon each resident's discharge from the facility.	F 661		
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 (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	F 758		2/20/19

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F 758	Continued From page 7 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: Based on record review and staff interviews the facility failed to complete an assessment for AIMs (Abnormal Involuntary Movement) for one of four residents receiving antipsychotic medications for unnecessary medications. Resident # 28. The findings included: Resident # 28 was admitted to the facility with diagnoses of Cerebral Infarction, Dementia with Behaviors, Anxiety, Major Depressive Disorder, Recurrent Severe Psychotic Symptoms, Irritability and Anger.	F 758	1. Resident #28 had AIMS completed on 3/2/18 & 6/1/18 2. An audit was completed on 1/29/19 by the clinical nurse consultant on current residents receiving antipsychotic medications. 100% of resident□s receiving antipsychotic medications had Abnormal involuntary movement (AIMS) completed on 2/15/19 3. On 2/15/19 the Director of nursing re-educated the licensed nurses on how and when to complete an AIMS on	

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F 758	Continued From page 8 Record review revealed an order dated 2/8/18 for an antipsychotic mediation, Olanzapine 7.5 mg 1 tablet at bedtime for psychotic disorder, related to dementia with behavioral disturbance. Record review revealed a baseline AIMs assessment was completed on 3/2/18 and a 3 month AIMs completed on 6/1/18 for abnormal involuntary movement due to possible side effects from the use of the antipsychotic medication. There was no documentation that a 6 month AIMs was completed to continue to monitor the patient for any abnormal involuntary movements. In an interview on 1/31/19 at 9:35 AM the Director of Nursing revealed when it was brought to her attention she did an audit and completed an AIMs for Resident # 28 on 1/30/19. The DON revealed last month the Consulting Pharmacist had asked for the missing AIMs to be completed. In an interview with the Consulting Pharmacist on 1/31/19 at 11:08 AM she revealed every 6 months she would look for an AIMs to be completed for any resident receiving antipsychotic medications.	F 758	residents taking anti-psychotic medications. 4. The director of nursing will audit any resident currently taking or newly prescribed antipsychotic□s monthly for 3 months to ensure that AIMS are being completed. 5. The Director of nursing will present the results of the visual audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in compliance.	
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.	F 880		2/20/19

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F 880	Continued From page 9 §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, 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	F 880		

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F 880	Continued From page 10 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 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 observations, record review and staff interviews, the facility failed to wash hands between resident to resident care for 3 of 3 residents (Residents #9, #40, and #5) during meal observation, and failed to prevent cross contamination by taking a glucometer case in and out of the resident room without cleaning the case or placing a barrier between case and table, and then stored the case on the medication cart for 1 of 1 residents (Resident #11) observed for blood sugar check. The findings included: 1. A meal observation was conducted 1/29/2019 at 12:12 PM when nursing assistant #1 (NA) took a meal tray to the Resident #9 in Room 129 B. The NA was not observed to wash her hands before entering the resident room. The NA sat the meal tray on the overbed table, then picked	F 880	1. Nurse Aide #1 served several patients meals trays while not washing her hands between each task and in and out the rooms. Nurse #1 also took a glucometer bag with patients monitor in it into the room. 2. Education will be provided to all staff to re-educate on the importance of infection prevention and transmission of infection. There will be a mandated 100% compliance for education on this matter. 100% staff education was complete by 2/14/19. 3. The SDC/infection prevention nurse will be monitoring the staff and completing the observation tool 3x a week x4 weeks starting 2/25/19-3/22/19. Monthly observation tools with infection control surveillance thereafter. 4. SDC/Infection prevention will monitor	

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F 880	Continued From page 11 up the bed remote and lowered the resident's head of bed, positioned herself at the head of the bed and used the draw sheet to pull the resident up in bed, and used the remote to raise the head of the bed back up. The NA then readied the meal tray for the resident and left the room without washing her hands. On 1/29/2019 at 12:13 PM, NA #1 went into Room 130 B and pulled up Resident #5's pants, put the resident's shoes on, helped the resident to stand and pulled his pants up. The NA washed her hands and left the room. On 1/29/2019 at 12:17 PM, NA #1 took a meal tray into Room 131 for Resident #40, then left the room without washing her hands and went back into Resident #5's room with the meal tray. The NA assisted the resident into a chair, moved the overbed table to the resident and readied the tray. The NA left the room without washing her hands and pushed the meal cart up the hall. On 1/29/2019 at 12:19 PM, NA #1 stopped at Room 129 B and assisted the Resident #9 who was coughing, into a more upright position. The NA assisted the resident with fluids from his tray and then used his silverware to cut up his food. The NA left the room without washing her hands and continued pushing the meal cart up the hall. An interview was conducted with NA #1 on 1/29/2019 immediately following at 12:23 PM. The NA stated she been trained at school and at the facility to wash her hands after assisting residents, and basically before or after doing anything. The NA stated she did wash her hands once, but she didn't know why she didn't wash them after touching the residents as she was just	F 880	and complete the tool. 5. If the POC is not 100% within compliance within the allotted time frame it will be amended and a PIP will be brought to QAPI and monitored until compliance is met.	

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 _____	01/31/2019

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

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F 880	Continued From page 12	F 880		

trying to get the lunch trays passed as quickly as possible.

On 1/30/2019 at 2:32 PM, an interview was conducted with the Staff Development/Infection Control Nurse, who stated she expected staff to wash their hands between each resident, whether they were passing meal trays or not.

On 1/31/2019 at 12:06 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected staff to wash their hands before and after caring for residents and in between residents when passing trays.

2. An observation was conducted on 1/31/2019 at 9:39 AM with Nurse #1 as she conducted a blood sugar check for the Resident #30 in Room 112 A. The Nurse took a black zippered bag from a row of labeled black bags in the medication cart drawer and put it on top of the medication cart. The Nurse opened the bag and inserted a glucose test strip into the glucometer that was in the bag and under a small strap. The nurse donned gloves and entered the resident's room, set the opened black bag with the glucometer still under the strap on the resident's overbed table. The nurse obtained the blood sample from the resident and tried to pick up the glucometer but could not get it out from under the strap with one hand, and picked up the black case, maneuvered the glucometer to the sample and waited for the result to appear. The nurse laid the black bag back on the overbed table, removed her gloves and took the bag and the used supplies to the medication cart to dispose of them. The nurse zippered the black bag with the glucometer inside and put the bag back in the medication cart drawer with other zippered and labeled bags.

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F 880	Continued From page 13 An interview was conducted with nurse #1 on 1/31/2019 at 9:43 AM. The nurse stated once an item when into a resident room, it stayed in the resident room, and she wouldn't take items from room to room. The Nurse stated the glucometers were cleaned on night shift but she didn't know which day. When asked why she took the glucometer bag in and out of the resident room without cleaning it, the nurse stated the inside of the bag was the only thing that touched anything and that was how she had been doing it since each resident had been given their own glucometers. An interview was conducted on 1/31/2019 at 11:56 AM with the SDC/Infection Control Nurse and the DON, who stated they expected the glucometer to be the only thing taken in and out of the resident room, and the glucometer was to be cleaned before and after use. The DON stated the glucometer bag should not be taken in and out of the resident room since it was stored on the mediation cart with other glucometer bags.	F 880		