	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION ((3) DATE SURVEY COMPLETED
		NH0176	B. WING		C 06/14/2019
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
ACCORDI	US HEALTH AT STATES	VILLE	LEY STREET VILLE, NC 2867	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
L 006	.2104(C) REQUIREN RENEWAL/CHANGE	IENTS FOR LICENSE	L 006		7/9/19
	Licensure and Certifi of the Division of Fac within one working da occurrence of: (1) change in adminis (2) change in the dire (3) change in facility or telephone number (4) changes in magni services; or (5) emergencies or s requiring relocation of temporary location av facility. This Rule is not met Based on record revi facility failed to notify Licensure and Certifi of Health Service Re- day following the cha The findings included Review of the facility Director of Nursing (I Upon entrance to the AM the Weekend Su Nurse #1 had resigne about a month ago, a DON. An interview with the	 clility Services ay following the stration; ector of nursing; mailing address; itude or scope of ituations of patients to a way from the as evidenced by: ew and staff interview the the Nursing Home cation Section of the Division gulation within one working inge of Director of Nursing. d: 2s file indicated the current DON) was Nurse #1. e facility on 06/09/19 at 10:15 pervisor (WS) stated that ed as the facility's DON and the facility had a new 		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaus it is required by the provisions of Federa and State law. L006 " The corrective action will be accomplished for those residents found have been affected by the deficient practice: 1. The facility notified the Nursing Hor Licensure and Certification Section of Health Service Regulation on 06/13/201	to ne
	Ith Service Regulation				
ORATORY I	DIRECTOR'S OR PROVIDER/ cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

STATE FORM

BQNH11

6899

If continuation sheet 1 of 2

PRINTED: 07/09/2019 FORM APPROVED

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
				С
	NH0176	B. WING		06/14/2019
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CCORDIUS HEALTH AT STATE	SVILLE	LEY STREET	_	
		VILLE, NC 2867		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
L 006 Continued From page	ge 1	L 006		
An interview was co Administrator on 06 Administrator confir been in that role sin she thought the corp of Health Service R believed she had co facility's DON chang was miscommunica completed the form. it was ultimately her	onducted with the /13/19 at 11:34 AM. The med that the current DON had ce 05/13/19. She stated that poration notified the Division egulation and the corporation ompleted the form for the ge. The Administrator stated it tion and she went ahead and . The Administrator stated that responsibility to make the puld have completed the form		 Address how the facility will identify other residents having the potential to b affected by the same deficient practice: No residents affected by deficient practice. " The following measures will be put into place or systemic changes made to ensure that the deficient practice will no recur: On 7/5/2019 the Administrator was serviced by the (RDO) Regional Director of Operations on completing DON notification and submitting within 24 hou?. Upon new hiring of a DON, the Administrator will submit change of notification and send a copy to the ROD ensure the change has been submitted. " The facility plans to monitor its performance to make sure that solutions are sustained; The Administrator will report to the Quality Assurance and Performance Improvement Committee monthly for 3 months of any changes submitted for a new DON. " Date of compliance July 9, 2019 	e t in ir urs.

BQNH11

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			COM	E SURVEY PLETED
		345128	B. WING				C / 14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		14/2015
ACCORDI	US HEALTH AT STATES	/ILLE		STA	ATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000	Initial Comments	INEDICAD SERVICES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345128 B. WING ILLE STREET ADDRESS, CITY, STATE, ZIF S20 VALLEY STREET STATESVILLE, NC 28677 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) PREFIX PREFIX V was conducted from e facility was found in requirements of CFR 483.73 ass. Event ID 154X11 F 561 3)(8) F 561 winst be frequency from resident self-determination ident choice, including but s specified in paragraphs (f) section. F 561 dent has a right to choose noluding sleeping and care and providers of health int with his or her interests, n of care and other of this part. A right to make so fhis or her life in the ant to the resident. dent has a right to interact ommunity and participate in oth inside and outside the Interact ommunity and participate in oth inside and outside the					
	06/09/19 to 0/14/19 th compliance with the r	ey was conducted from ne facility was found in equirements of CFR 483.73 ess. Event ID 154X11					
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-	(3)(8)	F 5	561			7/9/19
	promote and facilitate through support of res	right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f)					
	activities, schedules (waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
	with members of the	ident has a right to interact community and participate in both inside and outside the					
	religious, and commu interfere with the right facility. This REQUIREMENT	ident has a right to tivities, including social, nity activities that do not ts of other residents in the is not met as evidenced					
LABORATORY	by:	SUPPLIER REPRESENTATIVE'S SIGNATURE	 E		TITLE		(X6) DATE

Electronically Signed

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.

07/04/2019

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		. ,	ATE SURVEY OMPLETED
						С
		345128	B. WING			06/14/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
ACCORDI	US HEALTH AT STATES	/ILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG			PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 561	Continued From page	21	F 56	1		
		ew, staff and resident	1 00	Preparation and/or exe	cution of this plan	
		failed to honor a resident's		of correction does not c	-	
	-	owers scheduled on Sunday		admission or agreemen		
		sidents reviewed for choices		the truth of the facts alle		
	(Resident #16).			conclusions set forth in	the statement of	
				deficiencies. The plan o		
	The findings included	:		prepared and/or execute		
				it is required by the prov	isions of Federal	
		mitted to the facility on		and State law.		
	12/03/18 with diagnos					
	Parkinson's disease a	and hypertension.		E EC1 Colf Determinatio	-	
	Desident #1Cls Admis	aian Minimum Data Cat		F 561 Self Determinatio	n	
		sion Minimum Data Set ated 12/10/19 revealed it		The corrective action	on will bo	
	was very important fo			accomplished for those		
	religious services or p			have been affected by t		
	Resident #16's most i	recent quarterly MDS		1. On 06/28/2019 Res	sident # 16 was	
		/12/19 revealed, he had		interviewed by the facili		
		equired supervision for		regarding his preference		
	bathing.			he prefers to get his sho		
	0			#16 care plan was upda		
	Resident #16's Resid	ent Care Specialists care		by the Minimum Data S	et Nurse (MDS) to	
		revealed, his showers were		reflect the residents cho	pice of shower	
	scheduled for first shi Thursdays.	ft on Sundays and		days.		
		ident #16 on 06/10/19 at		The facility will iden		
		was adamant that he did		having the potential to b		
		scheduled on a Sunday		same deficient practice:		
		hurch services at a church		1. On 06/28/2019 Cur		
		did not like to be rushed to		a BIM score 9 and high		
		eted before leaving the		interviewed by the facilit		
	facility on Sunday mo			determine shower day p		
		this concern, about not scheduled on Sunday during		resident care plans were MDS nurse to reflect res		
		cil meeting (05/28/19) and a		shower days		
		n down and stated she		2. On 07/08/2019 the	facility social	
	would inform someon				esponsible party	1

Facility ID: 922999

If continuation sheet Page 2 of 70

					CONSTRUCTION	OMB NC	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				PLETED
		345128	B. WING				C
	ROVIDER OR SUPPLIER	545125			TREET ADDRESS, CITY, STATE, ZIP CODE	06/	14/2019
	NOVIDER OR SOLT EIER				20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO DATE
F 561	Continued From page	e 2	F	561			
		here had been no one to			of residents with a BIMs of 9 or below t	0	
		hanging his shower days			determine their shower preference. Th		
		hat resident council meeting.			residents care plans will be updated by		
		e was still receiving showers			the MDS nurse to reflect resident's cho	ice	
	on Sunday which was	s not his preference.			of shower days.		
	On 06/13/19 at 3:12 F	PM during an interview with			The following measures will be put	t	
		AD), she explained that her			into place or systemic changes made to		
	responsibility during t	he resident council meetings			ensure that the deficient practice will no	ot	
	was to document the	minutes of the meetings			recur:		
		er (SW) was the one who			1. On 06/19/2019 the Director of Nur	-	
		lents' concern, so she may			and social worker began re-education		
		lent #16 voice his concern.			Licensed nurses, CNA's, and activity st	taff	
		ent #16 attended nearly			on resident self-determination and		
	-	I meeting and was quiet, but hose to be. She added she			resident rights that residents have a choice of shower days. This re-educat	ion	
		realistic for Resident #16 to			will be complete by 07/05/2019. After the		
		showers on a different day			date nursing and activity staff will not b		
	than Sunday because				allowed to work until re-education is	•	
	services every Sunda				complete. This re-education will be		
		-			included in the orientation for new nurs	ing	
	On 06/14/19 at 9:55 A	AM an interview with Unit			or activity staff.		
		ealed, Resident #16 was			2. Systems altered is that each reside		
	alert and oriented and				or resident representative upon admiss		
	·	ers. The UM explained, she			will be asked shower preference days a	and	
	was aware that Resid				times. This will reoccur a minimum of		
		Vednesdays but did not			each quarter during the care plan		
	on the weekends.	because she did not work			meeting. 3. The RR will be contacted for those		
	on the weekenus.				 The RR will be contacted for those residents with a BIMS below 9 to 	,	
	An interview with the	Social Worker on 06/14/19			determine if shower schedules need to	be	
		l, her responsibility during			altered. This will be completed by	~~	
		neeting was to document the			07/08/2019		
	residents' concerns, t	out could not remember if			4. Upon admission a resident or RR	will	
		a specific concern during the			be communicate and it will be		
	last meeting. The SW	explained if the residents			documented in the care plan the		
	-	ays to be on certain days of			resident's preference shower days and		
	the week then their p	references should be			times		
	honored.						1

Facility ID: 922999

If continuation sheet Page 3 of 70

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 07/09/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345128	B. WING			06/14/2019	
	ROVIDER OR SUPPLIER	VILLE		52	REET ADDRESS, CITY, STATE, ZIP CODE 10 VALLEY STREET FATESVILLE, NC 28677	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	on 06/14/19 at 2:34 F should have asked re periodically after adm week they would pref stated it was not unre	with the Director of Nursing PM, she explained that staff esidents on admission and dission what days of the fer to receive showers. She easonable for Resident #16 ays changed from Sundays	F	561	 The facility plans to monitor its performance to make sure that solution are sustained; The Social worker will interview 5 residents weekly for 12 weeks to ensure residents are being allowed a choice in what days their showers will be done. audit will be documented on the choice audit tool. The social worker will present to the monthly Quality Assurance Performance committee (QAPI) the results of the choices audit tool for 3 months for identification of trends, actions taken, at to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring continued compliance. 	re This es he ce	
F 576 SS=C	CFR(s): 483.10(g)(6) §483.10(g)(6) The re- reasonable access to including TTY and TE the facility where calls overheard. This inclu- use a cellular phone a expense. §483.10(g)(7) The fac facilitate that resident individuals and entitie facility, including reas	sident has the right to have the use of a telephone, DD services, and a place in s can be made without being des the right to retain and at the resident's own cility must protect and t's right to communicate with es within and external to the	F 5	576	Date of compliance July 9, 2019		7/9/19

Facility ID: 922999

If continuation sheet Page 4 of 70

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/09/2019 MAPPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE	
		345128	B. WING				C 14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE		
		<i></i>		520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	/ILLE		STATESVILLE, NC	28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION DRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 576	facility; and (iii) Stationery, postag the ability to send ma §483.10(g)(8) The res and receive mail, and and other materials dures ident through a me service, including the (i) Privacy of such cor- with this section; and (ii) Access to statione implements at the res §483.10(g)(9) The res reasonable access to electronic communications (ii) At the resident's ex- expense is incurred b access to the resident (iii) Such use must co- law. This REQUIREMENT by: Based on Resident C the facility failed to de Saturdays. This had t 91 residents in the fac The findings included An interview with mer Council on 06/13/19 a mail was not delivered	e extent available to the ge, writing implements and il. sident has the right to send to receive letters, packages elivered to the facility for the eans other than a postal right to: mmunications consistent ry, postage, and writing ident's own expense. sident has the right to have and privacy in their use of ations such as email and s and for internet research. alable to the facility xpense, if any additional y the facility to provide such t. mply with State and Federal f is not met as evidenced Council and staff interviews, eliver mail to residents on he potential to affect 91 of cility. : mbers of the Resident at 10:14 AM, revealed they d to them on Saturdays.	F	 with Privacy The correct accomplished thave been affer practice: 1. Resident r June 8, 2019 w residents on June 3 	o forms of communication ctive action will be for those residents found to the deficient mail that was delivered to vas delivered to the une 9, 2019 by the activity	d to on	
	They reported it was i	d to them on Saturdays. not delivered on Saturdays virector not being in the		residents on Ju director.	une 9, 2019 by the activi	ty	

Facility ID: 922999

If continuation sheet Page 5 of 70

		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVI 0. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		E SURVEY IPLETED	
		345128	B. WING		06	C 6/14/2019	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ		
		VIII E		520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 576	Continued From page	e 5	F 576				
	building to deliver it a						
	•	ering the mail Monday		The facility will identify other	ner residents		
	-	ember of the Resident		having the potential to be affe			
	Council reported her	birthday was on 06/08/19		same deficient practice:			
		liked to have received her		1. Current residents that rec			
		eceive a birthday card her		the facility have the potential t	o be		
	-	her. They reported mail		affected			
		y is typically delivered the					
	following Monday.						
	During on interview w	with the Activities Director on		The following measures v into place or systemic change			
	-	vith the Activities Director on <i>I</i> , she reported she was		ensure that the deficient pract			
		ering mail through the week		recur:			
		hen she was in the building.		1. As of 07/01/2019 Busine	ss office.		
		kends when she was not		activity director, and reception			
		sponsibility of the weekend		were re- educated by the Adm			
	÷	r the mail when it arrived.		how to sort facility mail and er			
	She reported she car	me into the building on		resident mail was delivered w	thin		
	06/09/19 and noted t	he mail that was delivered on		twenty-four hours of receipt, in			
		en delivered to the residents		weekends. Newly hired staff			
		passed it out to the residents		office, receptionist, or activitie			
		ported she did not know why		educated during orientation.			
		ered on 06/08/19. She stated		educated by 07/09/2019 will n			
		livered by the post office d 2:00 PM on Saturday and		allowed to work until reeducat 2. A mail log was created to			
		that mail was delivered the		date a resident received mail			
	day it arrived at the fa			date it was delivered. This log			
		, -		completed daily when the mai			
	An interview with the	Weekend Receptionist on		by the activity director, busine			
	06/13/19 at 11:34 AM			receptionist. The log will be in			
		ng out mail to residents on		07/05/2019.			
		reported she did not pass out		3. Administrator will review			
		eived on 06/08/19 because		for 12 weeks to confirm reside			
	-	o do it. She reported the mail		delivery on the weekend. The			
		9 was delivered to the		begin on 07/08/2019 by the A			
	residents on 06/09/19	y.		The Administrator will interview			
	During an interview	with the Director of Nursing		interviewable residents weekly			
	During an interview v	vith the Director of Nursing PM, she reported it was her		month to ensure they are rece timely and document on a log			

Facility ID: 922999

If continuation sheet Page 6 of 70

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/09/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 06/14/2019
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP 520 VALLEY STREET STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 576	Saturdays by the staft the Activities Director Receptionist. She re too busy to pass out to working hours, they s member was located reported mail delivered	be delivered to residents on f member responsible, either or the Weekend ported if a staff member was the mail during their normal should ensure another staff to pass out the mail. She ed on Saturday should be y and should not be held	F 5	 76 4. The activity director withe monthly resident count any issues with mail delivered. The facility plans to missues with mail delivered of the sustained; The Social Services I interview 5 residents weel then 3 times a week for 2 ensure mail is delivered of 2. The Administrator will results of the interviews a quality assurance perform (QAPI) monthly for 3 mon recommendations or mod QAPI committee can mod 	cil minutes if ery reoccur. nonitor its that solutions Director will kly for 4 weeks months to n weekends. I present the nd logs to the nance committee ths for any fications. The
F 584 SS=D	CFR(s): 483.10(i)(1)- §483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environment use his or her person possible. (i) This includes ensur receive care and serv	onment. ght to a safe, clean, elike environment, including eiving treatment and ng safely.	F 5	3. Date of compliance J	uly 9, 2019 7/9/19

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/09/2019 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345128	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		5	STATESVILLE, NC 28677		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	97	F:	584			
	(ii) The facility shall ex	xercise reasonable care for					
	and comfortable inter						
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are					
	§483.10(i)(5) Adequa levels in all areas;	te and comfortable lighting					
	levels. Facilities initial	lly certified after October 1,					
	sound levels. This REQUIREMENT						
	interviews the facility	failed to clean a seatbelt			F 584 Safe/Clean/Comfortable/Homel Environment	ike	
					The corrective action will be		
						d to	
	(Resident #22).				have been affected by the deficient practice:	~	
	Findings included:				1. Seatbelt for resident # 22 was cleaned on 06/14/2019		
		and does not pose a safety risk. shall exercise reasonable care for of the resident's property from loss ousekeeping and maintenance sary to maintain a sanitary, orderly, is interior; lean bed and bath linens that are nr; rivate closet space in each as specified in §483.90 (e)(2)(iv); dequate and comfortable lighting as; omfortable and safe temperature sinitially certified after October 1, ntain a temperature range of 71 to or the maintenance of comfortable MENT is not met as evidenced ervations, record reviews and staff actility failed to clean a seatbelt 1 debris which was attached to a sheatbelts in wheelchairs 					
		d 03/22/19 revealed he was cognition for daily decision			The facility will identify other resid	ents	

Facility ID: 922999

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		MEDICAID SERVICES					3 NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION		DATE SURVEY COMPLETED	
						С		
		345128	B. WING				06/14/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ACCORDI	US HEALTH AT STATES	VILLE	520 VALLEY STREET STATESVILLE, NC 28677					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 584	Continued From page	e 8	F 58	4				
	making. The MDS fur required extensive as daily living except he with eating. An observation on 06 Resident #22 was se- main lobby with a gro were coming in and c	rther revealed Resident #22 sistance with activities of only required supervision 5/10/19 at 1:05 PM revealed ated in a wheelchair in the oup of residents and visitors out of the front door.		1 1 1	having the potential to be affected b same deficient practice: 1. Current residents with seatbelts visually observed by the unit mange 5/14/2019 and no other seatbelts we found to be soiled.	s were r on ere		
	 Resident #22 had a seatbelt fastened at his waist and the belt and buckle were coated with multiple areas of dried food spills and numerous stains that were easily visible. An observation on 06/10/19 at 4:24 PM revealed Resident #22 was sitting in a wheel chair in the main lobby. Resident #22 had a seatbelt fastened at his waist and the belt and buckle were still coated with multiple areas of dried food spills and numerous stains that were easily visible. An observation on 06/11/19 at 8:26 AM revealed Resident #22 was sitting in a wheelchair in the hallway and had a seatbelt fastened around his waist. The seatbelt was observed to be soiled on either side of the buckle with multiple areas of dried food spills and numerous stains that were easily visible. An observation on 06/12/19 at 2:49 PM revealed Resident #22 was sitting in a wheelchair in the hallway and had a seatbelt fastened around his waist. The seatbelt was observed to be soiled on either side of the buckle with multiple areas of dried food spills and numerous stains that were easily visible. 			e r 1 r 2 r a a a r	The following measures will be nto place or systemic changes mad ensure that the deficient practice will recur: 1. On 07/03/2019 the cleaning sch performed by the third shift CNA's w revised to include seatbelts. 2. On 07/03/2019 the director of n re-educated the licensed nurses, Ch and activity staff on the cleaning sch and that if a seatbelt is observed so notify the Director of nursing and or nursing supervisor so that someone	e to I not nedule as ursing NA's, nedule iled to		
				s c s v e c	be directed to change and clean the seatbelt. 3. On 07/08/2019 an inspection by Director of Nursing of residents with seatbelts will be performed 5x week weeks and 3 X a week for 8 weeks to ensure the seatbelts are not soiled. DON will document these findings of audit tool.	y the for 4 to The		
	waist. The seatbelt w either side of the buc dried food spills and r easily visible.	atbelt fastened around his vas observed to be soiled on kle with multiple areas of numerous stains that were n 06/13/19 at 12:38 PM, the		1 f	Indicate how the facility plans to monitor its performance to make sur solutions are sustained; 1. The Director of Nursing will rep indings of the observations to the G Assurance and Performance Comm	re that ort the tuality		

Facility ID: 922999

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	OMB NO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· /	MPLETED
							С
		345128	B. WING			0	6/14/2019
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				52	0 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 584	Continued From page	e 9	F 5	84			
		tated Resident #22's seatbelt			for any additional monitoring or		
	•	hen soiled. She further			modification of this plan monthly for 3	3	
		s seatbelt should be cleaned			months. The Quality Assurance and		
		was cleaned and as needed			Performance Improvement Committee	e	
	if it was soiled.	if it was soiled.			can modify this plan to ensure the fac		
					remains in compliance.		
	-	06/13/19 at 3:37 PM, the					
	•	Housekeeping explained he					
	had a schedule of wh				Dete of consultance, but 0, 0040		
		to be cleaned each month			Date of compliance July 9, 2019		
		at the nurses' station to chairs would be cleaned. He					
	•	Housekeeper to come in at eelchairs and the Nurse					
		shift took wheelchairs that					
		ed to a back hallway and					
		er cleaned them the NAs					
	took them back to res	sident rooms. He stated					
	seatbelts on wheelch	airs were also cleaned when					
	the wheelchair was c	leaned and confirmed					
		Ichair was last cleaned on					
	Friday 06/07/19. He	-					
		expectation for NAs to let him know if the chair or					
	anything on it such a	s the seatbelt was soiled.					
	During an interview of	on 06/13/19 at 3:56 PM, Unit					
	Manager #2 explaine						
		seatbelt when he was up in					
		confirmed he could unfasten					
	his seatbelt when rec	quested but he was at risk for					
		ear it for safety. She					
		22 would not let anyone feed					
		s the last independent thing					
		elf. She further explained					
	Resident #22 ate pureed food a	reed tood and he usually					
		p and on the seatbelt in his					
	wheelchair. She stat	p and on the seatbelt in his ed it was her expectation for tbelt when it was soiled. She					

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584 F 640 SS=D	was cleaned the seat She explained it was clean the seat belt wh because it was not jus responsibility. During a telephone in AM with Nurse Aide # assigned to care for F 06/09/19. She stated instructed to clean the wheelchair and did no his wheelchair. During an interview of Administrator stated in staff should clean the wheelchair when it wa Encoding/Transmitting CFR(s): 483.20(f)(1)-0 §483.20(f) Automated requirement- §483.20(f)(1) Encodir a facility completes a facility must encode the each resident in the fa (i) Admission assessment (ii) Significant change (iv) Quarterly review a (v) A subset of items of reentry, discharge, ar (vi) Background (face is no admission assess	belt should also be cleaned. everyone's responsibility to then they saw it was soiled at housekeeping's terview on 06/14/19 at 8:54 44 she confirmed she was Resident #22 on Sunday she had not been e seatbelt in Resident #22's of recall he had a seatbelt in n 06/14/19 at 3:04 PM, the t was her expectation that seatbelt in Resident #22's as soiled. g Resident Assessments (4) d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. ht updates. e in status assessments. assessments. upon a resident's transfer, id death. -sheet) information, if there		640			7/9/19

Facility ID: 922999

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/09/2019 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION	(X3) DATE	
			A. BUILDII	NG		(C
		345128	B. WING			06/	14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/II F		520 VA	ALLEY STREET		
				STATI	ESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	a facility must be capa CMS System informa contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, and the CMS System, incl (i)Admission assessment (ii) Annual assessment (iii) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (fac- initial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on record revif facility failed to compl discharge tracker Min assessment to the Ce Medicaid Services (C minimum required tim	able of transmitting to the tion for each resident is in a format that conforms to its and data dictionaries, dardized edits defined by ittal requirements. Within y completes a resident's must electronically transmit ind complete MDS data to luding the following: nent. nt. e in status assessment. tion of prior full assessment. tion of prior quarterly e upon a resident's transfer, nd death. e-sheet) information, for an MDS data on resident that nission assessment. trmat. The facility must ormat specified by CMS or, an alternate RAI approved t specified by the State and " is not met as evidenced ew and staff interview, the ete and transmit a himum Data Set (MDS) enters for Medicare and MS) system within the ne frame for 1 of 3 residents	F	As • ac ha	640 Encoding/Transmitting Resident ssessments The corrective action will be ccomplished for those residents found ave been affected by the deficient		
	Medicaid Services (C	MS) system within the the frame for 1 of 3 residents		ha	ccomplished for those residents found	l to	

Facility ID: 922999

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		0	C 5/14/2019
NAME OF P	ROVIDER OR SUPPLIER	1 6	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
			ŧ	520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES		5	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 640	Continued From pag	e 12	F 640			
	12/28/18 with diagno	nitted to the facility on ses that included heart		1. Resident #1 had his discharg completed and transmitted on 07/ by the facility Minimum Data Set (Coordinator.	02/2019	
	 failure and diabetes mellitus. Resident #1 was discharged from the facility on 02/20/19. Review of the resident's discharge tracker MDS revealed, it was not completed or transmitted to CMS within the required 14-day timeframe. During an interview with the MDS Coordinator (MDSC) on 06/14/19 at 10:59 AM, she confirmed that Resident #1's 02/20/19 discharge tracker had not been completed or transmitted to CMS as of 06/14/19. The MDSC explained, she normally waited 24 hours after the resident was transferred out of the facility before she completed the discharge summary in the event the resident 		 The facility will identify other in having the potential to be affected same deficient practice: The facility has conducted MI audits for residents requiring a dist assessment from 02/20/2019 thro 07/01/2019 by the (IDT) Interdisci Team to identify residents who ne have a discharge assessment sch and completed. The results of the did not identify any other discharge trackers that were not completed transmitted. The following measures will be a set of the following measures will be a solution. 	I by the DS scharge ugh plinary eded to neduled audits ie or		
	apparently forgot to H which caused her to transmission of the d An interview with the on 06/14/19 at 2:38 H probably waited to se from the hospital with the situation but rega completed and trans	y. The MDSC stated she keep track of Resident #1 miss the completion and lischarge tracker MDS. Director of Nursing (DON) PM revealed, the MDSC ee if the resident would return hin 24 hours and lost track of ardless she should have mitted the discharge opropriate 14-day timeframe.		 The following measures will c into place or systemic changes m ensure that the deficient practice y recur: The (MDS)Coordinator has b re-educated by the regional MDS consultant on 07/05/2019 on com of the discharge assessment and that these assessments are transi- timely. Newly hired MDS staff will educated during orientation. Any staff not educated by 07/09/2019 be allowed to work until reeducate 2. The alleged deficiency is isolar where education and quality assu will achieve compliance The MDS Coordinator will con weekly audit to ensure all discharge 	ade to will not een pletion verifying mitted be current will not ed. ated rance	

Event ID: 154X11

Facility ID: 922999

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	SURVEY LETED
		345128	B. WING				, 14/2019
NAME OF PI	ROVIDER OR SUPPLIER	I		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1	
ACCORDI	US HEALTH AT STATES	VILLE			VALLEY STREET ATESVILLE, NC 28677		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	ntinued From page 13		640	assessments have been scheduled beginning 07/08/2019. The MDS Coordinator will conduct audits weekly 4 weeks and monthly for 2 months.	for	
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ients	F		 The facility plans to monitor its performance to make sure that solution are sustained; 1. The director of nursing will be responsible to review the audits submit by the MDS coordinator weekly of discharge assessments and Final Validation Report (transmittal log) that shows complete and timely filing of fac assessments weekly for 4 weeks and monthly for 2 months 2. The director of nursing will be rev the results of the audits through month Quality Assessment and Performance Improvement (QAPI) and corrective actions taken as necessary and plan modified as needed. Date of compliance July 9, 2019 	tted ility iew	7/9/19
	§483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record revi facility failed to accura	of Assessments. t accurately reflect the is not met as evidenced iew and staff interview the ately code the Admission IDS) assessment in active			F 641 Accuracy of Assessments The corrective action will be		

Event ID: 154X11

Facility ID: 922999

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	MPLETED
						С
		345128	B. WING		c	6/14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	e 14	F 64	11		
		ampled residents reviewed lications (Resident #84).		accomplished for those have been affected by the practice:		
	The finding included:					
	_			1. The admission com		
		mitted to the facility on		assessment for Residen		
	fracture, diabetes me	ses which included hip		modified on 06/14/2019 diagnoses of Pseudobul		
				modification was transm		
		#84's Physician Orders dated		06/14/2019. The Minimu		
	02/20/19 revealed a l			(MDS) coordinator has b		
	every 12 hours for Pa	gram one capsule by mouth seudobulbar affect.		and re-educated by the on July 2, 2019 on impo	-	
	,			of her comprehensive as		
		#84's admission Minimum		section I (diagnosis). Fa	-	
	· · ·	essment dated 02/22/19		accurate assessments r		
	under Section I for A	84 had not been coded		use by the MDS coordin further re-education and		
	Pseudobulbar Affect.			disciplinary action up to	and including	
	During an interview w	vith the MDS Coordinator		termination of employme facility progressive disci		
	-	at 11:11 AM she explained,			onnary policy.	
		ormation from several				
		resident's medical record,				
		an's orders, to complete the		The facility will iden		
		s. The MDSC stated that he diagnosis was written		having the potential to b same deficient practice:	e affected by the	
		as admitted, the order could				
		ion in medical records		1. Section I of the m	ost recently	
		the resident's chart and		completed MDS as of Ju	-	
		on Resident #84's chart		current residents, will be		
	when she completed	the MDS.		accuracy by the regiona Modifications if needed		
	An interview with the	Director of Nursing on		and submitted by the MI		
		indicated, she felt human				
		the mental health diagnosis		The following meas		
		MDS, and it should not have		into place or systemic ch	-	
	been left off.			ensure that the deficient recur:	practice will not	

Facility ID: 922999

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			
	345128	B. WING			C / 14/2019
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
IUS HEALTH AT STAT	ESVILLE				
			STATESVILLE, NC 28677		
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETIO DATE
Continued From pa	age 15	F 641			
06/14/19 at 3:24 P	M she indicated she felt as if			•	
the mental health of	diagnosis should have been on		coding the MDS, specifically, s Newly hired MDS staff will be e during orientation. Any MDS s not been educated by 07/09/20	ection I. educated taff that has 019 will not	
			Minimum data sets per week x to ensure accuracy. After the 1 the regional MDS consult will re section I of random completed	12 weeks 2 weeks eview MDS's	
			 performance to make sure that are sustained; 1. Data obtained during the a process will be analyzed for pa trends and reported to Quality and Performance Improvement Committee by MDS coordinato 	solutions udit tterns and Assurance t r monthly x	
			effectiveness of the intervention determine if continued auditing	ns to is	
	F CORRECTION PROVIDER OR SUPPLIER IUS HEALTH AT STAT (EACH DEFICIE REGULATORY OF During an interview 06/14/19 at 3:24 P the MDSC was use progress notes for the mental health of	F CORRECTION IDENTIFICATION NUMBER: 345128 PROVIDER OR SUPPLIER IUS HEALTH AT STATESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345128 B. WING	F CORRECTION IDENTIFICATION NUMBER: A BUILDING 345128 B WING STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ISUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE ISUMMARY STATEMENT OF DEFICIENCIES B WING ISCONTINUED IP PREIN ISCONTINUE REGULATORY OR LSC IDENTIFYING INFORMATION) IP REFIN Continued From page 15 IP REFIN During an interview with the Administrator on 06/14/19 at 3:24 PM she indicated she felt as if the mental health diagnosis should have been on Regional MDS consultant on 0 Resident #84's admission assessment. F 641 2. Beginning 07/08/2019 Reg consultant will audit section 1 or Minimum data sets per week x to ensure accuracy. After the 1 the regional MDS consult will n section 1 of random completed during visits to ensure the facili maintains compliance • The facility plans to monite performance improvement Committee Will Quilt Section 1 or Amount completed during the equil on 3 months. At that time, the QU Assurance and Performance Improvement Committee Will Q	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING COM 345128 B. WING 06 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET IUS HEALTH AT STATESVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET SUMMARY STATEMENT OF DEPICIENCIES D PROVIDER PLAN OF CORRECTION 06 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCE ON SHOULD BE CROSS-REFERENCE ON SHOULD BE During an interview with the Administrator on 06/14/19 at 3:24 PM she indicated she felt as if the MDSC was used to only looking in the progress notes for diagnoses, but in any case, the mental health diagnosis should have been on Resident #84's admission assessment. F 641 1. MDS nurse was re-educated by the Regional MDS consultant on 07/02/2019 will not be enducated by 07/09/2019 will not be allowed to work until reeducated. 2 Beginning 07/08/2019 Regional MDS consult will review section 1 of 5 Minimum data sets per week x 12 weeks to ensure the acuitary maintains compliance • The facility plans to monitor its performance to make sure that solutions are sustained; 1 Data obtained during the audit process will be analyzed for patterns and trends and reported to Caudity Assurance and Performance to make sure that solutions are sustained; • The facility plans to monitor its performance to make sure that solutions are sustained;

Facility ID: 922999

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	-	ND HUMAN SERVICES			PRINTED: 07/09/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345128	B. WING		06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT STATES		:	520 VALLEY STREET	
Accordi				STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 644	Continued From page	e 16	F 644	1	
F 644 SS=D		ARR and Assessments	F 644		7/9/19
	pre-admission screer (PASARR) program u of this part to the max avoid duplicative test includes: §483.20(e)(1)Incorpo from the PASARR lev PASARR evaluation u assessment, care pla care. §483.20(e)(2) Referri all residents with new serious mental disord related condition for I a significant change i	tion. hate assessments with the hing and resident review under Medicaid in subpart C kimum extent practicable to ing and effort. Coordination we arating the recommendations vel II determination and the report into a resident's anning, and transitions of ng all level II residents and vly evident or possible der, intellectual disability, or a evel II resident review upon n status assessment. F is not met as evidenced			
	by: Based on record rev facility failed to reque Screening and Resid resident with a new n of 1 resident reviewer The Findings Include Resident #74 was ad 06/02/16. Resident # included generalized depressive disorder.	iew and staff interviews the est a Level 2 Preadmission ent Review (PASRR) for a nental health diagnosis for 1 d for PASRR (Resident #74). d: mitted to the facility on 474 had diagnoses that I anxiety disorder and major		 F 644 Coordination of PASARR and Assessments The corrective action will be accomplished for those residents four have been affected by the deficient practice: A level 2 PASARR screening was requested on 06/20/2019 for resident The facility will identify other residents having the potential to be affected by same deficient practice: On 07/03/2019 current residents 	ind to is t # 74 idents / the

Facility ID: 922999

If continuation sheet Page 17 of 70

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/09/2019 MAPPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C /14/2019
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
4000000				52	0 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 644	Continued From page	e 17	F	644			
F 644	physician visit. A review of Resident comprehensive Minin (MDS) dated 02/18/19 be cognitively intact for no psychosis, and no self or others. Reside having active diagnost disorder, depression, disorder, and psychost coded as not having a During an interview w Worker on 06/13/19 a did not have any resp PASRR numbers. Sh responsibility of the A request a review of a warranted. During an interview w Coordinator on 06/13 she made sure a resi screening before adm explained she comple she was notified by th significant change in or an exhibited behav not remember when t had a PASRR review have expected MDS I Resident #74 receive unspecified psychosis	 ied psychosis during a #74's most recent hum Data Set Assessment 9 revealed Resident #74 to or daily decision making with behaviors directed towards ent #74 was coded as ses that included anxiety post traumatic stress sis. Resident #74 was also a level II PASRR. with the facility's Social at 9:36 AM, she reported she bonsibility for the review of he reported it was the dmissions Coordinator to PASRR number, if with the Admission /19 at 9:39 AM, she reported dent had a PASRR hission into the facility. She eted review requests when he MDS Nurse of a condition, a new diagnosis vior. She stated she could the last time Resident #74 She reported she would Nurse #1 to notify her when d a new diagnosis of s. She also reported if she 	Fé	344	 audited by the Director of nursing and Managers from April 1 to June 30 to determine if a new diagnosis was add during a physician visit that would req a Level 2 PASARR screening. The following measures will be pu- into place or systemic changes made ensure that the deficient practice will r recur: On 07/03/2019 the Director of nur re-educated the licensed nursing staff MDS nurse and the nurse practitioner Level 2 PASARR screening and what prompts the screening. Newly hired licensed nursing staff, MDS staff, and nurse practioner's will be educated du orientation. Any licensed nursing staff MDS staff, and nurse practioner's that have not been educated by 07/09/201 will not be allowed to work until reeducated. Beginning on 07/08/2019 the unit manager and or the Director of nursin must initial progress noted by nurse practitioner, or medical doctor prior to going into the medical record to screed diagnosis changes or additions. The progress notes that are reviewed will 1 kept on a log by the unit manger and of Director of Nursing. The log will be do weekly times 4 weeks then monthly tin 2 months. 	ed uire uire ut to not rsing f, on f, t 9 g n for be or one	
	had been notified, she PASRR review at that	e would have requested a t time.			 If a new diagnosis is added that requires a level 2 PASARR screening log will be kept by the Director of Nurs 		
	During an interview w	ith MDS Nurse #1 on			who will communicate to the admissio	-	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	<u> </u>	· · · ·	MPLETED
						С
		345128	B. WING			06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 644	Continued From page	e 18	F 64	4		
	06/13/19 at 10:45 AM resident to have a sig	l, she reported if she noted a nificant change in condition nental health diagnosis, she		director if a level 2 PASA to be referred.	RR screen needs	
	Coordinator for a PASSR review. She reported she did not complete a referral for Resident #74 because she did not feel it was a significant change in cognition, therefore it did not warrant a PASRR review. During an interview with Nurse Practitioner #1 on 06/14/19 at 9:23 AM, she reported a resident with a diagnosis of unspecified psychosis would be considered to have a significant mental health diagnosis and would require "ongoing and continuous mental health" therapy.			 The facility plans to performance to make surare sustained; Beginning on 7/08/2 worker will review 5 new progress notes weekly for 	re that solutions 019 the social Physician	
				determine if a new diagn that requires a level 2 PA and document these find weeks then monthly for 2 2. The DON will review screening log weekly for team.	osis was added SARR screening ings weekly for 4 ? months. v the PASARR	
	on 06/14/19 at 12:37 expectation that PAS the criteria for a revie she would have expe	vith the Director of Nursing PM, she reported it was her RR reviews be requested if w was met. She reported cted a resident with a new ied psychosis to have a		 The DON will report audits to the Quality Assu Performance Improveme The Quality Assurance a Improvement Committee audits to make recomme ensure compliance is sus and determine the need auditing beyond the three 	urance and nt Committee. nd Performance will review the ndations to stained ongoing; for further	
F 655 SS=D		-(3)	F 65	Date of compliance	July 9, 2019	7/9/19
	Planning §483.21(a) Baseline (§483.21(a)(1) The fac	sive Person-Centered Care Care Plans cility must develop and care plan for each resident				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	that includes the instr effective and person- that meet professional The baseline care pla (i) Be developed within admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fact comprehensive care plan if the compre- care plan if the compre- care plan if the compre- ti) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fa- resident and their rep of the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fa- on behalf of the facilit (iv) Any updated infor of the comprehensive	uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information care for a resident ted to- l on admission orders. endation, if applicable. cility may develop a blan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not if the resident. resident is medications and treatments to be acility and personnel acting	F	655	5		

Facility ID: 922999

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 07/09/201 FORM APPROVE B NO. 0938-039
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C 06/14/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES			5	20 VALLEY STREET		
ACCOUNT				S	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 655	Continued From page	<u>></u> 20	Í F	655			
	Based on record rev	iew and staff interview the op a baseline care plan that		000	F 655 Baseline Care Plan		
	included minimum he provide effective pers resident with a urinar	althcare information to con-centered care for a y catheter (Resident #54) as a fall risk (Resident			 The corrective action will be accomplished for those residents fo have been affected by the deficient practice: On 06/14/2019 Resident # 54 minutes regioned to reflect the procession. 	care	
	The finding included:				plan was revised to reflect the prese an indwelling catheter and the care required for the catheter		
	facility on 02/28/19 an to the facility on 05/14	initially admitted to the nd most recently readmitted 4/19. Resident #54's euromuscular dysfunction of			2. On 06/12/2019 Resident # 198 plan was revised to reflect fall risk a interventions in place		
	dated 02/28/19 revea indwelling urinary cat Unit Manager (UM) # Review of the compre (MDS) dated 04/01/1 was moderately impa making and required	heter and was signed by			 The facility will identify other real having the potential to be affected by same deficient practice: On 07/02/2019 a review of basis care plans for admissions starting J of current residents with indwelling catheters and those that were a fall on admission to ensure the plan of or reflective 	y the eline une 1 risk	
		d an indwelling catheter and nt of bowel.			 The following measures will be into place or systemic changes made ensure that the deficient practice will 	le to	
	revealed no base line admission on 02/28/1	e care plan for the initial 9 was present.			recur: 1. Beginning on 06/21/2019 the M nurse /DON re-educated the license	IDS ed	
	06/12/19 at 9:42 AM. floor nurse, UM, or M initiate the baseline c admitted to the facility	ducted with UM #2 on UM #2 stated that either the DS Coordinator would are plans when a resident y. She added that the responsible for completing			nurses to start the base line care pla admission. New hires will be educat base line care plans during orientati licensed nursing staff that have not received education by 07/09/2019 w be allowed to work until reeducated	ted on on. All vill not	

Facility ID: 922999

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STATEMENT (S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	(X3) D	NO. 0938-03 DATE SURVEY OMPLETED
			A. BUILDING	<u> </u>		C
		345128	B. WING			06/14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	US HEALTH AT STATES	2V/IIIE		520 VALLEY STREET		
ACCONDI	US NEALIN AT STATES			STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 655	Continued From page	e 21	F 65	55		
		ms upon admission and this		2. The MDS nurse will bring	the base	
		g baseline care plans but		line care plan to the clinical m		
		would ensure that all the		meeting beginning 07/08/201	-	
		ts were completed. UM #2		placed on a log for review to		
		y Resident #54 did not have		base line is reflective of the re-		
		for indwelling urinary		status. The MDS nurse will br	•	
	catheters but stated	maybe it was an oversight.		care plans to morning meeting weeks.	g daily for 12	
	An interview was cor	nducted with the MDS		3. On 07/08/2019 the DON	will audit the	
		2/19 at 2:30 PM. The MDS		log for completion of all basel		
	coordinator confirme	d that no baseline care plans		plans on admissions weekly f		
	-	for Resident #54's indwelling		to ensure the care plan is refl		
	-	e added that she expected		those that have indwelling cat	theters and	
		or the UM to complete the		that are a fall risk.		
		pon admission to the facility Id know how to take care of				
	the resident appropri			The facility plans to moni	tor its	
				performance to make sure that		
	An interview was cor	nducted with the Director of		are sustained;		
	Nursing (DON) on 06	6/13/19 at 8:10 AM. The DON		1. The DON will report the	results of the	
	-	cted baseline care plan to be		audits to the Quality Assurance		
	-	sion to the facility either by		Performance Improvement C		
		or the UMs so that the direct		The Quality Assurance and P		
	care stall knew now	to care for the resident.		Improvement Committee will audits to make recommendat		
	An interview was cor	nducted with the		ensure compliance is sustain		
		14/19 at 3:04 PM. The		and determine the need for fu	• •	
	Administrator stated	that she expected baseline		auditing beyond the three (3)		
		ated upon admission so that				
		of how to care for the newly				
	admitted resident.			Data of compliance 1.1	0.0010	
	2 Resident #109 wa	s admitted to the facility on		Date of compliance July	9, 2019	
		s admitted to the facility off				
		haviors, weakness, and				
	The resident's admis revealed orders that	sion physician orders				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT STATES	/ILLE			20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	monitoring for the use antidepressants, and Capsule 30 milligram Mirtazapine 15 mg for (an antipsychotic) 50r A review of Resident revealed no dementia daily living (ADL) care care plan. Additional Resident #198 not be During an interview w 06/12/19 at 2:12 PM, aware of care needs resident care guide. Su unsure who develope guides and stated if tf guide, it would be diff resident required. Sho the level of care Resident buring an interview w 06/12/19 at 9:42 AM, responsibility of the a the baseline care plan admitted to the facility, completed within the in the facility. She rep care plans were comp into the resident's ele stated she was unsur baseline care plan ha reported it should haw During an interview w	e of anxiety agents, antipsychotics; Temazepam s (mg) for insomnia; r dementia, and Seroquel mg for anxiety. #198's baseline care plan a care plan, no activities of e plan or antipsychotic use ly, a resident care guide for en developed. with Nurse Aide #3 on she reported she was made by looking at the resident's She reported she was d or edited the resident care nere was no resident care icult to determine the care a e reported she was unsure dent #198 required. with Unit Manager #1 on she reported it was the dmitting floor nurse to begin n once a resident was y. She reported it should be first 48 hours a resident was ported once the baseline oleted they would be placed ctronic medical record. She e why Resident #198's d not been completed but we been completed. with the Director of Nursing AM, she reported it was her line care plans be	F	655			

Facility ID: 922999

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						<u>0. 0938-03</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		· · ·	E SURVEY PLETED	
						С	
		345128	B. WING			/14/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	•		
	US HEALTH AT STATES	MILLE	520				
ACCORDI			STA	TESVILLE, NC 28677			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 655	Continued From page	e 23	F 655				
		ity. She reported without the					
	completion of a base	line care plan, the floor staff					
		determining what care					
F 050	Resident #198 requir		5 050			7/0/40	
F 656	CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 656			7/9/19	
SS=D							
	§483.21(b) Compreh	ensive Care Plans					
		cility must develop and					
		nensive person-centered					
		sident, consistent with the th at §483.10(c)(2) and					
	§483.10(c)(3), that in						
		ames to meet a resident's					
		l mental and psychosocial					
		ied in the comprehensive					
		nprehensive care plan must					
	describe the following	g - are to be furnished to attain					
		ent's highest practicable					
		psychosocial well-being as					
	required under §483.	24, §483.25 or §483.40; and					
		would otherwise be required					
		.25 or §483.40 but are not					
		esident's exercise of rights ding the right to refuse					
	treatment under §483						
		ervices or specialized					
		s the nursing facility will					
	provide as a result of						
		a facility disagrees with the					
	rationale in the reside	RR, it must indicate its					
		h the resident and the					
	resident's representa	tive(s)-					
		als for admission and					
	desired outcomes.	eference and potential for					
	URN I NO ROCIDANT'S NR	storopoo and potential for	i 1			1	

Facility ID: 922999

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/09/2019 // APPROVED). 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		LETED
		345128	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				5	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	/ILLE		S	STATESVILLE, NC 28677		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	х	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CTION SHOULD BE COMPLETING THE APPROPRIATE DATE	
F 656	future discharge. Faci whether the resident's community was asses local contact agencies	lities must document s desire to return to the ssed and any referrals to s and/or other appropriate	F	656			
	entities, for this purpo (C) Discharge plans in plan, as appropriate, in requirements set forth section. This REQUIREMENT by: Based on observation interview the facility fat comprehensive perso resident with an indwa (Resident #54) and fat comprehensive, indivi- resident that required and toileting that inclu- assistance was needed (Resident #298) for 2 The findings included 1. Resident #54 was in	se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced Ins, record review and staff ailed to develop a In-centered care plan for a celling urinary catheter iled to develop a idualized care plan for a assistance with bed mobility ided how much staff ed to care for the resident of 3 sampled residents. Initially admitted to the			 F 656 Develop/Implement Comprehensive Care Plan The corrective action will be accomplished for those residents found have been affected by the deficient practice: On 06/12/2019 the Minimum Data nurse revised resident # 54 person- centered care plan in order that it may accurately reflect an indwelling cathete On 06/12/2019 the Minimum Data nurse revised resident # 298 Person-centered care plan in order that 	Set r. Set	
	to the facility on 05/14 diagnoses included no the bladder. Review of Resident # dated 02/28/19 revea indwelling urinary cath Review of the compre- (MDS) dated 04/01/19 was moderately impa	euromuscular dysfunction of 54's admission assessment led that she had an neter. thensive Minimum Data Set 9 revealed that Resident #54 ired for daily decision			 may accurately reflect the assistance required by staff with bed mobility and toileting The task segment in Point click ca that communicates to the certified nurs assistant was updated to reflect resider 54 indwelling catheter and resident # 2 amount of assistance required from stafor bed mobility and toileting. The facility will identify other resider 	ing nt # 98 ff ents	
		total assistance of two staff g. The MDS further revealed			having the potential to be affected by the same deficient practice:	ne	

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FO	ED: 07/09/2019 RM APPROVED NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345128	B. WING _		0	C 06/14/2019
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	US HEALTH AT STATES	/// / E		520 VALLEY STREET		
ACCORDI	US NEALIN AT STATES			STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page that Resident #54 had was always incontine Review of the Care A dated 04/07/19 and s Coordinator read in p indwelling urinary cat her hospitalization. Th patent and intact. Wil monitor level of functi as it pertains to the in Review of Resident # revealed no care plar catheter. An observation of Re 06/09/19 at 3:31 PM. bed with her eyes op She was observed to catheter that was dra collection bag that co milliliters (ml) of the c An interview was con Coordinator on 06/12 coordinator confirmed	e 25 d an indwelling catheter and nt of bowel. rea Assessment (CAA) igned by the MDS art, Resident #54 has an heter that was placed during he catheter seemed to be l proceed to care plan and on and avoid complications dwelling catheter. 54's medical record n for the indwelling urinary sident #54 was made on Resident #54 was resting in en and was alert and verbal. have an indwelling urinary ining clear yellow fluid into a ntained approximately 300 lear yellow fluid.	F 6	DEFICIENCY)	of current eters and ssistance was nursing ensure that care plan catheters tance d toileting. will be put es made to tice will not onal MDS ucation to the which r, Social etary, nent of sive care MDS and n during	
	catheter. She could n care plan for the indw stated it was just an o MDS Coordinator sta proceeded to care pla catheter as stated in t An interview was con Nursing (DON) on 06	ot explain why there was no relling urinary catheter but oversight on her part. The ted that she should have an for the indwelling urinary		 MDS Consultant. Any MDS staff that have not received ex 07/09/2019 will not be allowed until reeducated. 2. Beginning on 07/08/2019 MDS Consultant will review, a document on a log 3 complete -centered comprehensive car weekly for 12 weeks to ensur- plan reflects an indwelling cat 	taff or IDT ducation by d to work the Regional audit, and ed person e plans e each care	
	catheters to be care p	U		present and the amount of sta		

Facility ID: 922999

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		345128	B. WING		C 06/14/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	comprehensive care 2. Resident #298 was facility on 09/19/15 at on 05/23/19. Resider included: weakness, amputation of lower of Review of a care plar 02/10/17 read in part Activity of Daily Living performance deficit re amputation, impaired sided hemiplegia/hen care plan read, Resid current level of functi- review date. The inte MOBILITY: the reside DRESSING: the reside DRESSING: the reside assistance, PERSON requires staff assistan resident requires staff Review of the quarter dated 04/18/19 revea moderately impaired and required extensiv with bed mobility, toil The MDS further revea had experienced no f assessment. Review of a nurse's r AM read in part, Nurs reports that Resident fell to the floor while I provide care. Nurse of floor, supine lying on	planning process. s initially admitted to the nd most recently readmitted at #298's medical diagnoses hemiplegia, above knee extremity. That was initiated on , Resident #298 has an g (ADL) self-care elated to right above knee range of motion, and right niparesis. The goal of the dent #298 will improve on in ADLs through the rventions included: BED ent requires staff IAL HYGIENE: the resident nce, and TOILETING: the	F 65	 assistance that is required for be and toileting. The Regional MDS Consultant will complete a log fo audit. The facility plans to monitor performance to make sure that s are sustained; The Administrator will repor results of the audits to the Qualit Assurance and Performance Improvement Committee. The Q Assurance and Performance Improvement Committee will rev audits to make recommendation ensure compliance is sustained and determine the need for furth auditing beyond the three (3) mo Date of compliance July 9, 2 	its solutions t the ty uality iew the s to ongoing; er onths	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345128	B. WING				C 14/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORD	US HEALTH AT STATES	/ILLE			20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Sent to Emergency R Signed by Nurse #2. An interview was com 06/11/19 at 1:49 PM. 05/03/19 Resident #2 by NA #2 to provide in turned onto his side h floor. Nurse #2 stated sustained a head inju She added that she w Resident #298 and th she had cared for him not aware of how mar turn him in bed or to p relied on the NAs to k #2 confirmed she was information in Reside stated if she had any care or assistance that refer to Resident #298 An interview was com Coordinator on 06/11/ Coordinator reviewed and stated that she co assistance he require incontinence care. She the care plan to conta care for the resident #2 confirmed that it did n how much staff assist required for bed mobil	oom (ER) for evaluation. ducted with Nurse #2 on Nurse #2 stated that on 98 was being turned in bed noontinent care and once e kept going and fell to the that Resident #298 ry and was sent to the ER. vas not familiar with at night was the first night b. She stated that she was ny staff members it took to provide incontinent care and now that information. Nurse is not aware of the nt #298's care plan but question about how much at he needed she would B's care plan. ducted with the MDS (19 at 4:41 PM. The MDS Resident #298's care plan buld not tell how much d for bed mobility or the stated that she expected in enough information to but would also depend on ry.	F	656			

Facility ID: 922999

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 06/14/2019	
	ROVIDER OR SUPPLIER	VILLE	- 1	52	REET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 658 SS=D	facility. The DON sta plan to have sufficien care staff could safel #298.	ted she expected the care at information, so the direct y take care of Resident eet Professional Standards		656 658			7/9/19
	§483.21(b)(3) Compr The services provide as outlined by the co- must- (i) Meet professional This REQUIREMENT by: Based on record rev facility failed to admir be administered daily who had returned to but did not receive be his return to the facili sampled for unneces #34). Findings included: Resident #34 was ad 11/05/18 with diagno- tract infection, Parkin Alzheimer's disease, depression and anxie A review of the most Data Set (MDS) date Resident #34 was co decision making. Th Resident #34 require	rehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. Γ is not met as evidenced iew and staff interviews the hister medications ordered to a bedtime to a resident the facility from the hospital edtime doses on the day of ty for 1 of 6 residents sary medications (Resident mitted to the facility on ses which included a urinary ison's disease, seizures, diabetes, dementia, ety. recent quarterly Minimum d 04/05/19 revealed gnitively intact for daily e MDS also revealed d limited assistance for g except he only required			 F 658 Services Provided to Meet Professional Standards The corrective action will be accomplished for those residents found have been affected by the deficient practice: Resident # 34 received medications as ordered on 06/05/2019. The facility completed a medication error report and notified the medical director. The facility will identify other reside having the potential to be affected by the same deficient practice: Any resident(s) admitted since survexit, until 6/30/19 were reviewed to ascertain ordered medications were transcribed to the medication administration record (MAR), medication were received from the pharmacy, and administered as ordered. No discrepancies found. 	d nts e /ey	

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	-				FORM	D: 07/09/2019
	S FOR MEDICARE &	MEDICAID SERVICES			OMR NC	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED
		345128	B. WING			C 14/2019
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2013
				20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
				DEFICIENCY)		
F 658	Continued From page	29	F 658			
	A review of an incider	nt report dated 05/30/19 at				
		esident #34 had a fall from a		The following measures will be put	t	
		ng room. The report further		into place or systemic changes made t		
		ed at 7:15 PM and requested		ensure that the deficient practice will n		
	for Resident #34 to be	e sent to the hospital.		recur:		
				1. Beginning on 06/19/2019 the		
		note dated 06/04/19 at 4:41		Licensed nurses were re-educated by	the	
		t #34 returned to the facility		Director of Nursing which included		
	from the hospital.			Admission/readmission required		
				procedures; verify all orders with the		
	-	's orders dated 06/04/19		physician, orders verified with second		
	indicated in part the formedications:	bilowing bedtime		nurse after medication orders were entered correctly into the facility electro	onic	
		psule 100 milligrams (mg)		medical record medication administrat		
		outh at bedtime for seizures.		record, fax all pharmacy orders to		
		1 tablet by mouth at bedtime		pharmacy as soon as they are receive	d	
	for dementia with beh	-		and put a copy of the faxed confirmation		
				in the Director of Nursing (D.O.N.) box		
	A review of a Medicat	ion Administration Record		call pharmacy for verification that orde	rs	
	(MAR) dated 06/04/19	9 revealed Dilantin Extended		were received and that they will be		
		e 5 capsules by mouth at		delivered with the next pharmacy run,		
		but the space to document		document in nurses progress note who		
	the medication was b	lank.		spoke to at the pharmacy with date an		
				time. Newly hired licensed staff will be		
	Seroquel 25 mg by m	ated 06/04/19 revealed		educated during the orientation proces Current licensed nursing staff will not b		
	dementia with behavi			allowed to work after 07/09/2019 until	e	
	document the medica	•		reeducated.		
				2. New resident orders and any new		
	During an interview o	n 06/12/19 at 3:33 PM,		admission/readmission charts will be		
		was not assigned to care for		reviewed starting 6/30/2019 during AM	l	
		4/19 when he returned from		clinical meeting by the Interdisciplinary		
	the hospital but if ther	re was no documentation on		team (IDT) members that includes at a		
	the MAR next to the r	nedication it meant it wasn't		minimum the Director of Nursing (D.O.	N.),	
	given.			Minimum Data Set (MDS) Nurse, and		
				Administrator PRN, Monday-Friday, ar	nd	
		terview on 06/13/19 at 11:18		weekends by the RN Weekend		
	AM, Nurse #5 confirm	ned she worked on 06/04/19		Supervisor. Review to include; new or	ders	

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CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU	0938-03 JRVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLE	TED
					С	
		345128	B. WING			/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
ACCORD	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 658	Continued From page	30	E 6	58		
	during the evening sh give Resident #34 me because some of his when he came back f explained Unit Manag medication list and re	ift. She stated she did not edications that evening medications had changed from the hospital. She ger #1 had to go through the	ged properly faxed to the pharmacy, medication orders were entered correct into the facility electronic medical reco medication administration record, medications received as ordered and or		armacy, entered correctly e medical record n record, ordered and on medications have	
	Director of Nursing ex- report from a Nurse a Resident #34 returned She verified a facsimi medication list from th initialed by the Family once she had approve medications could be system for the medica further stated a blank medication was not g expectation Resident his bedtime medication During an interview of Family Nurse Practition the medication list fro #34 and stated her ini- the list. She further s for residents to receiv however she did not f of Dilantin and 1 miss Seroquel would have	d to the facility on 06/04/19. le (fax) copy of the ne hospital had been v Nurse Practitioner and ed the medication list the entered into the computer ations to be given. She space on the MAR meant iven and it was her #34 should have received ons on 06/04/19. n 06/14/19 at 9:15 AM, the poner confirmed her initials on m the hospital for Resident itials indicated she had seen tated it was her expectation re medications as ordered feel 1 missed bedtime dose sed bedtime dose of caused harm for Resident the medications over several oblem. She further expect for staff to		 The facility plans to performance to make su are sustained; Starting 07/01/2019 Admission/re-admission completed by the Directo (D.O.N.) and Minimum D Nurse, or a designated r administrator weekly M-f then 3x/week for 2 month include; any new resider admission/readmission of properly faxed to the pha medication orders were of into the facility electronic medication administratio medication s received as the medication cart, and been administered as or 2. Results of the audit presented by the D.O.N. Quality Assurance Perfo Improvement (QAPI) x3 timeframe determined by members 	re that solutions New order(s) and audits will be or of Nursing bata Set (MDS) nurse for 4 weeks, hs. Audit to to orders and orders were armacy, entered correctly medical record n record, ordered and on medications have dered. s will be at the monthly rmance months or until a	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FOF	D: 07/09/20 MAPPROV 0. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345128	B. WING		06	C 5/14/2019
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/ILLE		0 VALLEY STREET FATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 658	Manager #1 explainer to the hospital and the 24 hours they were con- stated all current Phy discontinued and new computer system whe the facility. She expla Resident #34's medic 06/04/19 and Resident his bedtime doses of when she came to wo asked her if Resident been discontinued. So up on the computer a were not showing up she called computer so computer assigned the incorrect MAR. She so that Nurse #5 should	n 06/14/19 at 10:01 AM, Unit d when a resident was sent ey were gone for more than onsidered discharged. She sician orders had to be v orders were put into the en the resident returned to ained she recalled she put rations into the computer on nt #34 should have received medications. She explained ork the next day a Nurse #34's medications had she stated she pulled them nd they were all active but on the MAR. She stated support and was told the	F 658	• Date of compliance July 9, 3	2019	
F 677 SS=D	at 10:40 AM revealed and would only smile down when asked qu During an interview o Administrator stated i residents to receive th when they returned fr	n 06/14/19 03:04 PM, the t was her expectation for neir medications at bedtime	F 677			7/9/19
	out activities of daily I	ent who is unable to carry iving receives the necessary good nutrition, grooming, and				

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/09/2019 M APPROVED <u>D. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			Сом	E SURVEY PLETED
		345128	B. WING			C / 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT STATES	/ILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 677	Continued From page personal and oral hyg This REQUIREMENT		F 67	7		
	interview the facility fa daily living care to a d soiled with food left ov before feeding the res	ns, record review, and staff ailed to provide activities of lependent resident who was ver from the breakfast meal sident the lunch meal for 1 d for activities of daily living		 F 677 ADL Care Provided for Dep Residents The corrective action will be accomplished for those residents f have been affected by the deficien practice: Resident # 75 was assisted w care after lunch on 6/9/19 with no 	ound to t ith ADL	
	04/30/19 and readmit #75's diagnoses inclu infarction, weakness, Review of a care plan in part, Resident #75 Living (ADL) self-care to decreased mobility The goal read, Reside level of function in AD The interventions incl resident requires assi	mitted to the facility on ted on 05/22/19. Resident ded: dementia, cerebral dysphagia, and others. initiated on 05/14/19 read has an Activity of Daily e performance deficit related and cognitive impairment. ent #75 will improve current Ls through the review date. uded: bathing/shower: the stance, dressing: the stance, eating: the resident		 effects to the resident. The facility will identify other r having the potential to be affected same deficient practice: Current residents that are depwith ADLS are at risk for the deficipractice. Upon observations no oth residents were found to have not r AM care prior to meals. The following measures will b 	by the endent ent eceived	
	is totally dependent of Review of the quarter dated 05/25/19 reveal moderately impaired f and required extensiv member with eating a person with dressing. that Resident #75 req of one person with per	n staff for eating. Iy Minimum Data Set (MDS) led that Resident #75 was for daily decision making e assistance of 1 staff nd extensive assist of two The MDS further revealed uired extensive assistance		 into place or systemic changes material ensure that the deficient practice v recur: Beginning on 06/19/2019 the unit managers re-educated the CN Licensed nursing staff on assisting dependent residents with ADL's, to include timely am care after break to ensure clothes are changed after if soiled with food. Newly hired CN Licensed nursing staff will be educ during orientation. Any licensed st 	Ide to vill not DON/ IA's and fast and er meals As and ated	

Facility ID: 922999

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 06/14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • •
ACCORDI	US HEALTH AT STATES	/ILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 677	in bed with his eyes o nonverbal. He was clo was covered with a sh appeared unkempt. He combed and and ther on his chest and partit that contained eggs a material that resemble brown chunky materia was noted on the from gown and sheet that w An observation of Res 06/09/19 at 12:57 PM in bed with his eyes o stated he was waiting Resident #75 remaine gown and covered wit contained eggs and th that resembled oatmet on his chest and partit The same thick brown resembled oatmeal res with Nursing Assistan 06/09/19 at 1:22 PM. #75 his lunch meal. T eggs and thick brown resembled oatmeal res	 Resident #75 was resting open, he was alert but othed in a hospital gown and heet. Resident #75 lis hair had not been e was a towel laying partially ally in the bed next to him and thick brown chunky ed oatmeal. That same thick al that resembled oatmeal to f Resident #75's hospital was covering him. sident #75 was made on a covering him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was nade on a cover ing him. sident #75 was cover ing him. sident #75 and interview to cover ing and was cover ing him. sident #75 and interview to that was cover ing him. sident #75 and interview to the front of and sheet that was cover ing him. 	F 677	 CNAs not educated by 07/09/20 be allowed to work until reeduca 2. The unit managers/supervit make rounds on all units 5 x we weeks during meal times to ensire sidents that require assistanc ADLS do not have on food solle prior to meals. The rounds will the 07/08/2019 3 times a week for 4 then weekly for 4 weeks, then m 2 months. Finding will be docut a log and given to the DON for make sure that are sustained; 1. The facility plans to monito performance to make sure that are sustained; 1. The Director of nursing will the results of the visual round a the quality assurance performance for any recommendations or modifications. The QAPI commit modify this plan to ensure a fac remains in compliance. Date of compliance July 9, 	ated. sors will sek for 12 sure that e with ed clothing begin on 4 weeks, nonthly for mented on review. r its solutions present udits to nce months ittee can ility

Facility ID: 922999

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED C NAME OF PROVIDER OR SUPPLIER 345128 B. WING 06/14/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677 520 VALLEY STREET STATESVILLE, NC 28677 06/14/20		TMENT OF HEALTH AN RS FOR MEDICARE & I						FORM	D: 07/09/2019 MAPPROVED D. 0938-0391
345128 B. WING 06/14/20* NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET ACCORDIUS HEALTH AT STATESVILLE STATESVILLE, NC 28677 STATESVILLE, NC 28677 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION 06/14/20*	STATEMENT C	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, ,				(X3) DATE COMF	SURVEY PLETED
ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (C			345128	B. WING			_		
ACCORDIUS HEALTH AT STATESVILLE STATESVILLE, NC 28677 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (C)	NAME OF PF	PROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	ACCORDI	DIUS HEALTH AT STATES	VILLE				7		
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
 F 677 Continued From page 34 grabbed his catmeal and split it on his gown and splet. NA #1 confirmed that she had not provided any ADL care to Resident #75. She stated that they facility was really short staffed and there was only 4 NAs in the building and after breakfast she had to assist one of the other NAs with a transfer and then started ther round at the other end of the hall. NA #1 stated that she had not gotten to Resident #75 before the lunch trays arrived at the unit, so she had to stop and pass the lunch trays and then assist Resident #75 with his lunch. NA #1 stated that she would complete Resident #75 should have been cleaned up after breakfast and should not have eaten lunch still solied from the breakfast meal but added "It had been so busy" and she had just not had time. An interview was conducted with the Weekend Supervisor (VK) on 06/12/19 at 9.25 AM. The WS confirmed that Bew as ware of the staffing challenges but stated she was not parent that hor beakfast food. She added that she had not with research #75 that day but was not aware that the staff had not been able to provide ADL care to Resident #75 she dual not been able to provide ADL care to Resident #75 that day but was not aware that the staff had not been able to provide ADL care to Resident #75 that day but was not aware that the staff had not been able to provide ADL care to Resident #75 that day but was not aware that the staff had not been able to provide ADL care to Resident #75 that day but was not aware that the staff had not been able to provide ADL care to Resident #75 that day but was not aware that the staff had not been able to provide ADL care to Resident #75 that day but was not aware that the staff had the expected ADL to be provide ADL care to Resident #75 that MAY but have notified the nures. She added that she expected ADL care to Resident #75 that MAY but have notified the nures. An interview was conducted with the Unit Manager (UM) #2 on 06/12/19 at 9.458 AML UM #2 	F 677	grabbed his oatmeal a sheet. NA #1 confirme any ADL care to Resid they facility was really only 4 NAs in the built had to assist one of th and then started her m hall. NA #1 stated that Resident #75 before th unit, so she had to sto and then assist Resid #1 stated that she wo ADL care after lunch a #1 stated that Reside cleaned up after brea eaten lunch still soiled but added "it had bee not had time. An interview was com Supervisor (WS) on 0 WS confirmed that sh and was aware of the stated she was not pe schedules changes. T unacceptable that Re while soiled with brea she had not witnessed was not aware that th provide ADL care to h The WS stated that if to complete the ADL of NA #1 should have no that she expected AD resident when needed have no ADL care by An interview was com	and spilt it on his gown and ed that she had not provided dent #75. She stated that y short staffed and there was ding and after breakfast she he other NAs with a transfer round at the other end of the at she had not gotten to the lunch trays arrived at the op and pass the lunch trays lent #75 with his lunch. NA build complete Resident #75's and get him cleaned up. NA ent #75 should have been kfast and should not have d from the breakfast meal en so busy" and she had just ducted with the Weekend 06/12/19 at 9:25 AM. The he was working on 06/09/19 e staffing challenges but ermitted to make any The WS stated that it was isident #75 was fed lunch ikfast food. She added that d Resident #75 that day but he staff had not been able to him prior to the lunch meal. there was not enough staff care to Resident #75 then obified the nurse. She added bL to be provided to every d and it was "excessive to lunch time."	F	677				

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		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/09/20 RM APPROVE NO. 0938-039
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		ATE SURVEY
		345128	B. WING			C 06/14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ACCORDI	US HEALTH AT STATES			520 VALLEY STREET		
			_	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 677	Continued From page	e 35	F 6	77		
	stated that the staff s	hould have cleaned up				
		t fed him lunch while soiled				
		2 stated "no one would want ver them." She added that				
		ould be completed by lunch				
	•	75 should have been cleaned				
	up prior to being serv	red lunch.				
	An interview was con	ducted with the Director of				
		5/13/19 at 8:07 AM. The DON				
		cted ADL care to be provided				
		lent #75 should have been eing served his lunch meal.				
	cleaned up prior to be	enig served his idner mear.				
	An interview was con					
		14/19 at 3:04 PM. The				
		that she expected Resident prior to his lunch being				
	served. She further s	tated that she expected ADL				
	-	when needed and certainly				
F 689	before lunch. Free of Accident Haz	ards/Supervision/Devices	F 68	30		7/9/19
	CFR(s): 483.25(d)(1)					110/10
	§483.25(d) Accidents	8.				
	The facility must ensu					
		sident environment remains azards as is possible; and				
		esident receives adequate				
	supervision and assist accidents.	stance devices to prevent				
	This REQUIREMENT	Γ is not met as evidenced				
	by: Based on observatio	ons, record reviews, staff,		F 689 Free of accident		
		er interviews the facility failed		Hazards/Supervision/Device	es	
	to prevent a depende	ent resident from falling from				
	bed and sustaining in	juries during the provision of		 The corrective action w 	vill he	

Facility ID: 922999

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/09/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 06/14/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·
ACCORDI	US HEALTH AT STATES			520 VALLEY STREET	
ACCORDI				STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 689	One staff member wa with incontinence car out of bed and fell to received treatment at sustained as a result laceration to the head a fractured clavicle. The findings included Resident #298 was in	nts (Resident #298) sion to prevent accidents. as providing Resident #298 e when the resident rolled the floor. Resident #298 the hospital for injuries of this fall which included; a d that required 3 sutures and	F 689	 accomplished for those residents have been affected by the deficie practice: Resident # 298 current interrelated to the incident on 5/3/19 a place. The interventions included changing the bed and ensuring 2 were utilized when performing car The facility will identify other having the potential to be affecte same deficient practice: 	ent ventions are in 2 CNA's are in bed
	included: weakness, amputation of lower e	298's medical diagnoses hemiplegia, above knee extremity, and others.		 Current residents that are at falls or that have fallen are at risk deficient practice The following measures will 	< for the
	Activity of Daily Living performance deficit re amputation, impaired sided hemiplegia/hen care plan read, Resid current level of function review date. The inte MOBILITY: the reside DRESSING: the reside assistance, PERSON requires staff assistant resident requires staff	elated to right above knee range of motion, and right niparesis. The goal of the lent #298 will improve on in ADLs through the rventions included: BED ent requires staff assistance, dent requires staff IAL HYGIENE: the resident nce, and TOILETING: the		 into place or systemic changes mensure that the deficient practice recur: 1. An audit completed by the M coordinator on 07/03/2019 of car of residents with falls in the last 3 ensure that interventions are on a plan and in place. 2. Beginning on 07/03/2019 the nurses were re-educated by DON documentation and assessment after a resident fall. New employer receive this education during orie Any licensed nursing staff that has received education by 07/09/201 be allowed to work until after received to work unt	e will not MDS re plans 30 days to the care e licensed N on the required ees will entation. ave not 9 will not
	read in part, Residen OT on 06/30/17. His read, hygiene and gro	t #298 was last evaluated by current level of function		3. Beginning on 07/03/2019 the were re-educated by the DON or following the care plans for interv related to preventing falls and on	e CNA's า ventions

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STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTI		(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345128				06	C 5/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP CODE	1 00	/14/2013
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULI SS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 689	at bed level), and dree extensive assistance upper body. The eval did not indicate how of required for each task The quarterly Minimu 04/18/19 revealed that moderately impaired and required extensive with bed mobility, toil The MDS further revea had experienced no f assessment. A facility document til Specialist Assignment read in part, Resident receive a shower on second shift and was bladder. Under transfit mechanical lift (2 assist restraint/bedrails/possist blank and contained	ng: did not test (dependent essing: continues to require with max assistance for luation and plan of treatment much staff assistance was k. Im Data Set (MDS) dated at Resident #298 was for daily decision making ve assistance of two person eting, and personal hygiene. ealed that Resident #298 falls since the previous teld "Resident Care at Sheet" and dated 04/25/19 t #298 was scheduled to Tuesday and Sunday on incontinent of bowel and fer/ambulation it stated	F	the Karde this educ CNAs tha 07/09/20 until reed 4. On 0 complete fall to ens remains a root caus during cli 07/08/20 5. The each fall new inter coordinat 6. Begi care shee PCC Kard will be up assistance living and	7/08/2019 the DON and ID a root cause analysis of ea sure the intervention in plac appropriate. The IDT will re- e analysis daily as needed nical meeting beginning on 19. care plan will be updated a to reflect the review or addi ventions by the MDS	y tion by ork T will ach se eview fter tion of ent the dex el of	
	read in part, Nursing to Nurse #2 that Resi He fell to the floor wh provide care. Nurse # laying in the floor sup mat. There was blood with a cross necklace frontal area above ey Ice and pressure app occipital (back of hea	ted 05/03/19 at 6:14 AM Assistant (NA) #2 reported ident #298 was on the floor. tile NA #2 was turning him to #2 observed Resident #298 oine position on the bedside d noted under his head along e. Swelling noted to left rebrow with bleeding noted. olied. Laceration noted to td), area with large amount Medical Services (EMS)		performa are susta 1. The an audit, of assista and docu with falls the asses complete updated o 2. The	facility plans to monitor its nce to make sure that solut ined; Director of Nursing will con- which includes appropriate ance while providing ADL ca ment findings for all resider weekly for 12 weeks to ens ssment, documentation are for 3 days and intervention on the care plan. Director of nursing will cond ent the results of the audits	duct level are nts sure ns duct	

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					CONCTRUCTION		O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1 Y	E SURVEY IPLETED
					- -		С
		345128	B. WING			0	6/14/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT STATES	VILLE			20 VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	Continued From page	e 38	F 68	39			
	called. Signed by Uni				which will include appropriate level of		
		-			assistance while providing ADL care a		
		note dated 05/03/19 at 7:59			fall interventions to the quality assurar		
	-	#2 reports that Resident r. He fell to the floor while NA			performance committee (QAPI) month for 3 months for any recommendations		
	#298 was on the noo				modifications. The QAPI committee ca		
		the floor, supine lying on			modify this plan to ensure a facility		
		oted under his head and			remains in compliance		
	laceration with large amou						
		R) for evaluation. Signed by					
	Nurse #2.				• Date of compliance July 9, 2019		
	Review of Emergenc	y Room (ER) notes dated			Date of compliance only 0, 2010		
		, per EMS the patient was in					
		alth until this morning when					
		rolled the patient in bed and					
		and landed face first on the sustained approximately a 2					
		d was unable to brace the					
		tion found the patient to					
	-	atoma that was bleeding as					
	well as an obvious sh						
		t nondisplaced clavicular					
		s scalp laceration was ed appropriate and given the					
	clavicle fracture was						
		tion was deemed necessary					
	will continue previous	sly placed sling. The patient					
	was deemed appropr	iate to return to the facility.					
		nt provided by NA #2 with no					
		ert, it was 5:00 AM and I was					
		nd Resident #298 was soiled					
		l gathered my linen and sident #298 up. NA #2 wrote					
		front side then she rolled him					
		an his back side. After he					
	was clean on both the	e front and back side NA #2					
	indicated she gathere	ed all her dirty linen and trash					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/09/2019 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345128	B. WING					C 14/2019
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT STATES	/ILLE			20 VALLEY STREET TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 689	then ready to put the Resident #298, so shi right side and he fell t so fast "I did not have statement was signed Attempts to speak to 06/11/19, 06/12/19, at unsuccessful. An initial interview wa #298 on 06/09/19 at 1 recently received a ne was washing him up a #298 could not explai stated he was bleedin the hospital and they back home. Another i with Resident #298 on stated that he could n staff member that was 05/03/19 but stated th seen her and the first Resident #298 stated up and rolled him off t third shift usually one to help him but when had someone to help "he feels much safer i helping but stated "the getting it done." An interview was con 06/11/19 at 1:49 PM. 05/03/19 NA #2 stated the floor. She stated so on the floor and NA #	NA #2 indicated she was clean brief and pad under e again rolled him to his o the floor and it happened time to respond." The I by NA #2. NA #2 were made on nd 06/13/19 were s conducted with Resident 2:37 PM. He stated that he ew bed because the staff and fell out of bed. Resident n how he fell out of bed but 19 from his head and went to fixed him up and sent him nterview was conducted n 06/12/19 at 10:41 AM. He ot recall the name of the s providing care to him on lat was the first time he had time she had cared for him. that she was washing him the bed. He added that on staff member would come NA #5 was there she always her. Resident #298 stated	F 6	89				

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STATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	O. 0938-03 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		СОМ	PLETED
		345128	B. WING			С
	ROVIDER OR SUPPLIER	345120		STREET ADDRESS, CITY, STATE, ZIP CO		/14/2019
	NONDER OR SOFT EIER			520 VALLEY STREET	DL	
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From pag	e 40	F 68	9		
		eplied she was providing				
	care to him when she	e turned him on his side he				
		the floor. Nurse #2 stated				
		ed the room Resident #298 or face up between the 2				
		he was alert and verbal.				
		was a lot of blood coming				
		oted a laceration with some				
		e area and she immediately				
		ea. She added that she was				
		dent #298 and that night was d cared for him. She added				
	•	f how many staff members it				
		ed or to provide incontinent				
	care and relied on the					
		2 stated that Resident #298				
		ts to her but when EMS ain of some arm pain. She				
		ed the on call medical				
		ily and sent Resident #298				
		luation and completed the				
	required paperwork.					
		a gold cross necklace on his ed that the cross may have				
		n because it was directly				
		vas covered with blood. She				
	stated that when she	left after her shift Resident				
	#298 had not yet retu	urned from the hospital.				
	An interview was cor	nducted with the				
	Administrator and the					
		06/11/19 at 2:17 PM. The				
		r the incident with Resident				
	-	#2 to come back to the				
		nacted the event, so they curred. The CNC stated that				
		as that Resident #298 had 2				
	-	ovements through the night				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M				FC	TED: 07/09/2019 DRM APPROVED NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
	345128	B. WING			C 06/14/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
			520 VALLEY STREET		
ACCORDIUS HEALTH AT STATESV	ILLE		STATESVILLE, NC 28677		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
 #298 on his right side I (amputation site) over that threw him out of th added that his bed at t and there was, nothing the floor. The CNC cor providing care to Resid 05/03/19. The CNC stal laceration came from t around his neck. The A after the event they ch 2 person assist and ad bed. She stated that th Care Specialist Assign communicate resident care staff. The Adminis mobility status would of department and Unit M that information on the Assignment Sheet and up each time they cam information. When the reviewed the Resident Assignment Sheet for place when the resider agreed that it did not c would be required to ta The Administrator state Resident Care Special contain information on resident including how needed to safely care to An observation of NA # Resident #298 was con 10:31 AM. NA #5 was 	She stated that they NA #2 turned Resident he threw his left stump the edge of the bed and he bed to the floor. She he time had no side rails to grab and he just fell to firmed that NA #2 was dent #298 by herself on ated they believe the the cross pendant he wore Administrator stated that anged Resident #298 to a ded positioning rails to his he facility used the Resident ment Sheet to mobility status to the direct strator stated that the come from the therapy Manager #1 would place e Resident Care Specialist d the staff would pick one he to work and have the Administrator and CNC c Care Specialist Resident #298 that was in nt fell on 05/03/19 they contain the information that ake care of Resident #298. ed that she expected the list Assignment sheet to how to care for the many staff members were	F 6	89		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		RINTED: 07/09/2019 FORM APPROVED MB NO. 0938-0391 (3) DATE SURVEY C 06/14/2019 (X5) COMPLETION DATE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION
F 689	that she took care of I was familiar with his of she always had 2 peo- his fall on 05/03/19 will of his right sided weat An interview was come Rehab on 06/12/19 at Rehab stated that the was on OT caseload with the facility's morning r in-house communicat the Unit Managers that resident. That form will functional status and place that information Specialist Assignment NAs, so they knew how care for the resident. stated that if the resident therapy had occurred status from the last the still be accurate. An interview was come (UM) #1 on 06/12/19 that she was not at the #298 fell from bed but stated that Resident # required 2-person assis knowledge the Reside Assignment Sheet into	e his bed bath and hout incident. NA #5 stated Resident #298 regularly and care needs. She stated that ople in the room even prior to hen providing care because kness. ducted with the Director of t 4:32 PM. The Director of e last time Resident #298 was December of 2018 tion only. He stated that in meeting they have an tion form that they gave to at was responsible for the ould include mobility and the Unit Manager would on the Resident Care t Sheet and then give to the ow to safely and properly The Director of Rehab lent was re-evaluated by would start over again. If no , then the resident functional terapy involvement would ducted with Unit Manager at 4:53 PM. UM #1 stated to facility when Resident t was told about it. She old that NA #2 was providing thim out of bed. UM #1 #298 has always and still sistance and to her	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/09/2019 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345128	B. WING					C 14/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page her that night and tha Resident #298 from fa	t would have prevented	F	689				
	An interview was com Nursing (DON) on 06, stated she was not the occurred but stated sl aware of the incident. Resident #298's Resid Assignment sheet that when the resident fell indicate how many stat that night to take care added that since assuch had identified the nee Resident Care Special planned to start using of the electronic medi would be clearer to the take care of the reside confirmed that the stat assistance Resident # "we had a systemic but An interview was come Practitioner (NP) on 0 stated that when she 05/03/19 UM #1 inform stated they had called she was told that the she rolled him to his sis bed. The NP stated the they noted a fractured	ducted with the Director of /13/19 at 8:16 AM. The DON e DON when the fall he had since been made . The DON reviewed dent Care Specialist at was in place on 05/03/19 and confirmed that it did not aff members were needed e of Resident #298. She uming the role of DON she ed to restructure the alist Assignment sheet and g the Kardex that was a part ical record which in her mind he staff of how to properly ent. The DON again aff did not know how much #298 required and stated,						
	The NP stated that sh	t no surgery was necessary. ne expected the staff to do to keep the resident safe						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690 SS=D	CFR(s): 483.25(e)(1)- §483.25(e) Incontiner §483.25(e)(1) The fac resident who is contin admission receives so maintain continence u condition is or becom not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive asses ensure that- (i) A resident who entri indwelling catheter is resident's clinical con- catheterization was no (ii) A resident who entri indwelling catheter or is assessed for remov- as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate to prevent urinary tract in continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive asses ensure that a resident receives appropriate to restore as much norm possible. This REQUIREMENT by:	-(3) nce. cility must ensure that thent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's asment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore ent possible. esident with fecal on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to he is incontinent of bowel treatment and services to he is incontinent of bowel treatment and services to hal bowel function as	F	690	E 690 Bowel Bladder Incontinence		7/9/19
	-	ns, record review, and staff			F 690 Bowel Bladder Incontinence		

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				PRINTED: 07/09/20 FORM APPROVE OMB NO. 0938-03
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
	345128	B. WING		C 06/14/2019
ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
US HEALTH AT STATES	VILLE			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE COMPLETION
Continued From page	e 45	F 690		
interview the facility f	ailed to secure a indwelling		Catheter UTI	
	•		accomplished for those resident	s found to
-			practice: 1. Resident # 54 indwelling ca	atheter
on 02/28/19 and mos facility on 05/14/19. F	02/28/19 and most recently readmitted to the cility on 05/14/19. Resident #54's diagnoses cluded neuromuscular dysfunction of the		was secured on 06/14/2019to p tugging or pulling	revent
(MDS) dated 04/01/1 was moderately impa making and required members with toiletin that Resident #54 ha was always incontine	9 revealed that Resident #54 hired for daily decision total assistance of two staff ig. The MDS further revealed d an indwelling catheter and ent of bowel.		 having the potential to be affected same deficient practice: 1. On 06/14/2019 the DON and manager conducted a visual aud current residents with indwelling to ensure they are secured. Any 	ed by the Id/or unit dit of catheters findings
06/09/19 at 3:31 PM. bed with her eyes op She was observed to catheter that was dra collection bag that co milliliters (ml) of the co indwelling urinary cat secured to Resident a be pulled across the connected to the drait on the side of the bed or discomfort at this t An observation of Re 06/10/19 at 11:29 AM in bed with her eyes of	Resident #54 was resting in en and was alert and verbal. have an indwelling urinary ining clear yellow fluid into a ontained approximately 300 clear yellow fluid. The heter was not anchored or #54's leg and was noted to front of her brief and nage bag that was hanging d. Resident #54 denied pain ime. sident #54 was made on 1. Resident #54 was resting open. Resident #54's		 into place or systemic changes is ensure that the deficient practice recur: Beginning on 06/19/2019 to licensed nursing staff and the C be re-educated by the DON on the and procedures for proper anchoring/securing of catheter to Newly hired licensed nursing staff cNAs will be educated in orientation. 	made to e will not he NA's will the policy ubing. aff and ation. 7/09/2019
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER US HEALTH AT STATES SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page interview the facility f urinary catheter tubin pulling for 1 of 2 resid indwelling catheter ca The findings included Resident #54 was ini on 02/28/19 and mos facility on 05/14/19. F included neuromuscu bladder. Review of the compre (MDS) dated 04/01/1 was moderately impa making and required members with toiletin that Resident #54 ha was always incontine An observation of Re 06/09/19 at 3:31 PM. bed with her eyes op She was observed to catheter that was dra collection bag that co milliliters (ml) of the co indwelling urinary cat secured to Resident # An observation of Re 06/10/19 at 11:29 AM in bed with her eyes of	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345128 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 interview the facility failed to secure a indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 2 residents reviewed for urinary indwelling catheter care (Resident #54). The findings included: Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING Continued From page 45 interview the facility failed to secure a indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 2 residents reviewed for urinary indwelling catheter care (Resident #54). F 690 The findings included: Resident #54 was initially admitted to the facility on 02/28/19 and most recently readmitted to the facility on 05/14/19. Resident #54's diagnoses included neuromuscular dysfunction of the bladder. F Review of the comprehensive Minimum Data Set (MDS) dated 04/01/19 revealed that Resident #54 was moderately impaired for daily decision making and required total assistance of two staff members with toileting. The MDS further revealed that Resident #54 had an indwelling urinary catheter that was draining clear yellow fluid into a collection bag that contained approximately 300 milliters (ml) of the clear yellow fluid. The indwelling urinary catheter was not anchored or secured to Resident #54's leg and was noted to be pulled across the front of her brief and connected to the drainage bag that was manging on the side of the bed. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was resting in bed with her eyes open. Resident #54 was res	S FOR MEDICARE & MEDICAID SERVICES CORRECTION (X1) PROVICERSUPPLIERCULA (X2) MULTPLE CONSTRUCTION A BUILDING

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/09/ FORM APPRC OMB NO. 0938-(OVED
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 06/14/2019)
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C		
ACCORDI	US HEALTH AT STATES			520 VALLEY STREET		
Accordi	SO NEALMAN ONAILO			STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETING COMPLICATING COMPLETING COMPLICATING COMPLICATING COMPLICATING COMPLICATING COMPLICATING COMPLICATING COMPLICATING COMPLICATING COMPLICATING COMPLICATINA COMPLICATING COMPLICATING COM	TION
F 690	Continued From page	e 46	F 69	90		
	yellow fluid into a dra side of the bed. The i	inage bag hanging on the ndwelling urinary catheter		education during orientatio	n.	
	leg and again was publicled and connected to side of the bed. Reside discomfort but not spurinary catheter. An observation of Re 06/11/19 at 8:08 AM. bed with her eyes op- urinary catheter was The indwelling urinary or secured to Reside out the side of her brit that was hanging on the An observation of Re 06/12/19 at 12:03 PM in bed with her eyes of	secured to Resident #54's Illed across the front of her o the drainage bag on the dent #54 verbalized general ecific to her indwelling sident #54 was made on Resident #54 was resting in en. Resident #54's indwelling draining clear yellow fluid. y catheter was not anchored nt #54's leg and was running ef into the collection bag the side of the bed. sident #54 was made on 1. Resident #54 was resting open. She had an indwelling was not anchored or secured		 The facility plans to me performance to make sure are sustained; Beginning on 07/08/20 and/or Unit manager will co audits for 12 weeks of all in catheters to ensure compli- anchoring of tubing and pla- log. The Director of nursing the results of the audits to assurance performance co (QAPI) monthly for 3 month recommendations or modif QAPI committee can modif ensure a facility remains in 	that solutions 019 the DON onduct weekly ndwelling ance with ace on an audit g will present the quality mmittee ns for any fications. The fy this plan to	
	pulled up over the sid connected to the drai	lling urinary catheter was le of her brief and then nage bag that hung on the catheter was draining clear dent #54 denied any		Date of compliance Ju	ly 9, 2019	
	confirmed that she wa and was familiar with that she performed ca emptied the catheter nurse how much outp stated that the nurse anchoring or securing	06/12/19 at 1:38 PM. NA #3 as caring for Resident #54 her needs. NA #3 stated atheter care every day, bag, and reported to the but Resident #54 had. She				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING				C 14/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORD	US HEALTH AT STATES	VILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	 was not anchored or a notified the nurse. NA not noticed that Reside was not anchored and it to the nurse. An observation of Reswith Nurse #3 were comparison of the eyes open. Her in was pulled through the pulled across the from to the drainage bag head. Nurse #3 confirm urinary catheter tubin pulling across the from She stated that all incomposite to the appropriate would immediately and tubing. An interview was con on 06/12/19 at 2:19 P that it would be a good the indwelling urinary #54's leg. She added fed through her brief a of the bed to ensure i not pull and cause distance anchoring or securing catheter tubing for Restance that she expected the ended the ended the ended the ended the ended to ensure i not pull and cause distance anchoring or securing catheter tubing for Restance the ended to ensure i not pull and cause distance anchoring or securing catheter tubing for Restance the ended th	e 47 secured she would have A #3 confirmed that she had dent #54's catheter tubing d therefore had not reported sident #54 and interview onducted on 06/12/19 at 4 was resting in bed with dwelling urinary catheter e right side of her brief and t of her brief and connected anging on the left side of the ned that the indwelling g was not anchored and was nt of Resident #54's brief. Iwelling catheter tubing o her leg and it was the urse to ensure that it was ly. Nurse #3 stated that she nchor the resident's catheter ducted with Unit Manager #2 M. Unit Manager #2 stated d idea to anchor or secure catheter tubing to Resident that the tubing should be and hung on the same side t drained properly and did scomfort to Resident #54.	F	690			

Facility ID: 922999

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 06/14/2019	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORDI	US HEALTH AT STATES	VILLE		20 VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO	
F 690	Continued From page or tugging on the resi		F 690			
F 695 SS=D	Administrator stated to catheter tubing to be times to prevent pulling resident.	4/19 at 3:04 PM. The that she expected indwelling anchored or secured at all	F 695		7/9/19	
	The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the compreher care plan, the resider and 483.65 of this sure this REQUIREMENT by: Based on observation interviews, the facility physician's order for a resident who receive cannula from an oxyg #86) and also failed the according to a physician to a ph	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. T is not met as evidenced whs, record reviews and staff r failed to obtain a administration of oxygen for red oxygen through a nasal gen concentrator (Resident		 F 695 Respiratory/Tracheostomy Ca and Suctioning The corrective action will be accomplished for those residents fou have been affected by the deficient practice: Resident #86 discharged on 06/10/2019 		
	09/24/15 with diagnos Alzheimer's disease,			 Address how the facility will ider other residents having the potential t affected by the same deficient praction An audit of all residents with oxyorders to ensure that oxygen is provided 	o be ce: /gen	

Event ID: 154X11

Facility ID: 922999

If continuation sheet Page 49 of 70

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		ATE SURVEY
			A. BUILDING	3		
		345128	B WING			C
		345126	B. WING	STREET ADDRESS, CITY, STATE, ZIP		06/14/2019
NAME OF PI	ROVIDER OR SUPPLIER				CODE	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE
F 695	Continued From page	e 49	F 69	15		
				as ordered by the physici	an. Audit	
	The resident's most re	ecent annual Minimum Data		completed on 07/05/2019		
	. ,	08/19 revealed Resident #86		Nursing		
		d in cognition for daily		2. A Visual audit of resid		
	decision making. The	d extensive assistance with		completed by the DON or validate a resident that is		
	•	g and oxygen was not		oxygen has an order and	•	
i	indicated.	g and oxygen was not		with an order for oxygen a		
		#86's monthly Physician's 9 revealed there was not an				
	order for the resident			The following measu	res will be put	
		to receive oxygen.		into place or systemic cha		
	Further review of Phy	vsician's orders dated		ensure that the deficient	•	
		09/19 revealed there were		recur:		
	no orders for oxygen.			1. On 07/05/2019 Lice		
	.			educated by DON/UM rec		
		n on 06/09/19 at 12:14 PM		importance of following pl		
		ng in bed with a nasal and the oxygen tubing was		for oxygen, ensuring thos orders for oxygen are rec		
		en concentrator next to her		administering oxygen an		
		ncentrator was turned on to 2		obtained, and documenta		
	liters per minute.			completed in the MAR/TA		
				will receive education dur	ing orientation.	
	-	n on 06/10/19 at 2:55 PM		As of 07/09/2019 licensed		
		ng in bed with a nasal		re-educated will not be al		
		and the oxygen tubing was		until reeducation is receiv		
		en concentrator next to her neet to her		2. Beginning on 07/08/2 be conducted by Director		
	1.5 liters per minute.			Nursing/Nurse Managers		
				residents with oxygen to		
	A review of a Physicia	an's order with a revised		provided and with an orde		
		ated to send to Resident		physician. This audit will I		
		room for a peripheral		all residents with oxygen		
	inserted central cathe	eter (PICC) line placement.		12 weeks. The DON/UM		
	A roviow of a Nursala	prograss note dated		MAR 3 times a week for 1		
	A review of a Nurse's 06/11/19 at 9:16 AM t			ensure residents are rece ordered.	aving oxygen as	
		σ_{f} or including of πz	1			1

Facility ID: 922999

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	COMPLETED	
					С	
		345128	B. WING		06/14/20	19
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMP	(X5) PLETION DATE
F 695	Continued From page	e 50	F 69	95		
	AM, the weekend Nur did not recall seeing a oxygen for Resident # residents who receive order it. During an interview o Unit Manager #2 she diagnosed with pneur she had a chest x-ray resident needed oxyg get a Physician's orde After review of Reside she stated an order s for Resident #86's ox someone had put oxy she was not sure who when they had placed confirmed Resident # emergency room for a 06/11/19 and had not During an interview o the Director of Nursin expectation Resident order for oxygen. She that the Nurse forgot During a telephone in AM with Nurse Aide (assigned to Resident 06/09/19 and recalled on. She stated Resid her she needed to pu the oxygen concentra	yen staff were supposed to er to administer oxygen. ent #86's physician orders hould have been obtained ygen. She further stated ygen on Resident #86, but o had put the oxygen on or d it on Resident #86. She 86 had gone to the a PICC line placement on the returned to the facility n 06/13/19 at 12:38 PM with g she stated it was her #86 should have had an e explained it was her guess to enter the order.		 The facility plans to monitor is performance to make sure that so are sustained; The director of nursing will refindings of the audits and observative Quality Assurance and Perfor Committee for any additional more or modification of this plan month months. The Quality Assurance a Performance Improvement Commican modify this plan to ensure the remains in compliance Date of compliance July 9, 2 	plutions port the ations to mance hitoring ly for 3 nd hittee e facility	

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HUMAN SERVICES EDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
345128	B. WING				C 14/2019
		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LE					
EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
1 ity since April 2019 as an 06/14/19 at 3:04 PM with ated it was her be and oxygen order for her expected for staff to s and administer oxygen an's order. mitted to the facility on ntly readmitted on s medical diagnoses ure, heart failure, chronic lisease, and others. ata Set (MDS) dated Resident #89 was daily decision making assistance with activities further revealed that ortness of breath and no g the assessment ctor (MD) order dated at 2 liters per minute via lent #89 was conducted <i>N</i> . Resident #89 was yes closed and had oxygen concentrator was nd was set to deliver 5 lent #89 was conducted Resident #89 was resting	F	695			
	DICAID SERVICES DICAID SERVICES DENTIFICATION NUMBER: 345128 LE MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 1 1 ity since April 2019 as an 06/14/19 at 3:04 PM with ated it was her be and oxygen order for her expected for staff to a and administer oxygen an's order. mitted to the facility on ntly readmitted on s medical diagnoses ure, heart failure, chronic isease, and others. ata Set (MDS) dated Resident #89 was daily decision making assistance with activities further revealed that ortness of breath and no the assessment ctor (MD) order dated at 2 liters per minute via ent #89 was conducted 1. Resident #89 was yes closed and had oxygen concentrator was and was set to deliver 5	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 345128 B. WING LE MENT OF DEFICIENCIES IDENTIFYING INFORMATION) ID PREF TAG 1 F 1 F 46/14/19 at 3:04 PM with ated it was her be and oxygen order for her expected for staff to as and administer oxygen an's order. F mitted to the facility on ntly readmitted on s medical diagnoses ure, heart failure, chronic isease, and others. ata Set (MDS) dated Resident #89 was daily decision making assistance with activities further revealed that ortness of breath and no of the assessment the assessment ctor (MD) order dated tt 2 liters per minute via ent #89 was conducted 1. Resident #89 was yes closed and had oxygen concentrator was nd was set to deliver 5 ent #89 was conducted Resident #89 was resting	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 345128 B. WING	Dipervipersuperuperupercuant (X2) MULTIPLE CONSTRUCTION JDENTIFICATION NUMBER: A BUILDING 345128 B. WING LE STREET ADDRESS, CITY, STATE, ZIP CODE S20 VALLEY STREET STATESVILLE, NC 28677 NENT OF DEFICIENCIES pp. DENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION NOT SHOULD CROSS-REFERENCE TO THE APPROPRIATION TAG UBENTIFYING INFORMATION) F 695 1 F 695 ity since April 2019 as an and administer oxygen and's order. F 695 mitted to the facility on the reacted for staff to as and administer oxygen and's order. F 695 mitted to the facility on the appropriation of the reacted that continues, and others. F 695 ata Set (MDS) dated Resident #89 was daily decision making assistance with activities further revealed that of these of breath and no the assessment F 695 ctor (MD) order dated the 2 liters per minute via F 699 was conducted F 695 ent #89 was conducted F 695 F 695	HUMAN SERVICES FOR DICAID SERVICES OMB NC DICAID SERVICES OMB NC JBOUDERSUPLIERCLA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION JBUILDING

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345128	B. WING				C / 14/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	oxygen in his nose. T sitting next to the bed liter per minute. An observation and ir were conducted on 00 Resident #89 was in 1 open. He was alert ar his nose. The oxygen next to his bed and w minute. Resident #89 shortness of breath a oxygen off and on ove the nurses would set bed and make sure it which he thought was An observation of Reson 06/12/19 at 11:57 resting in his bed with oxygen in his nose. T sitting next to the bed liter per minute. An interview was con Assistant (NA) #7 on confirmed that she was #89 and was familiar stated that Resident # times and she would the nurse was respon rate. NA #7 stated that room with Resident # had his oxygen in pla An interview was con 06/12/19 at 2:04 PM. Resident #89 had bea	he oxygen concentrator was and was set to deliver 4 hterview with Resident #89 5/11/19 at 8:09 AM. resting in bed with his eyes nd verbal. He had oxygen in concentrator was sitting as set to deliver 4 liters per denied any cough or nd stated he has worn er the years. He stated that the concentrator next to his was set to the right amount a 2 liters per minute. sident #89 was conducted AM. Resident #89 was his eyes closed. There was he oxygen concentrator was and was set to deliver 4 ducted with Nursing 06/12/19 at 1:52 PM. NA #7 as taking care of Resident with his care needs. She #89 wore his oxygen at all reapply it if it came off, but sible for the setting the flow at each time she was it the 89 she would make sure he ce.	F	695			

Facility ID: 922999

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345128	B. WING _				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT STATES	/// E		5	20 VALLEY STREET		
ACCORDI	US HEALIN AT STATES			S	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 695	added that he wore th per the MD order on O receiving 2 liters of ox confirmed that she wa #89 and confirmed that minute and stated, "he he should be on 2 lite flow rate to 2 liters per each nurse should be every day and stated flow rate when she wa An interview was como on 06/12/19 at 2:22 P that Resident #89 has most readmission. She should be checking th shift and making sure rate. Unit Manger #23 changed she would et and a nurse note expl changed. Unit Manag Resident #89 to be or as ordered by the MD An interview was como Nursing (DON) on 06 stated that oxygen sh nurse every shift to er delivered at the correct expect Resident #89 to per the MD order. An interview was como Practitioner (NP) on 0 stated that she expect	the oxygen continuously and 06/06/19 he should be oxygen per minute. Nurse #3 as taking care of Resident at he was on 4 liters per e should not be on 4 liters rs." Nurse #3 adjusted the r minute and stated that checking the oxygen rate that she had not noticed the as in the room earlier. ducted with Unit Manager #2 M. Unit Manager #2 stated a been on oxygen since hid the stated that the nurses the oxygen flow rate every it was at the correct flow stated that if flow rate was expect to see a new order laining why the order had er #2 stated she expected in the correct dose of oxygen ducted with the Director of (13/19 at 8:14 AM. The DON ould be checked by the nsure the oxygen was being ct flow rate. She would to be on 2 liters of oxygen	F	\$95			
	oxygen to be given as	ordered by the medical					

Facility ID: 922999

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345128	B. WING				C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/ILLE			20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Administrator on 06/1 Administrator stated t be delivered to the re- ordered by the MD. Sufficient Nursing Sta	4/19 at 3:04 PM. The hat she expected oxygen to sident at the rate that was ff		695 725			7/9/19
SS=D	§483.35(a) Sufficient The facility must have the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res- resident assessments and considering the n diagnoses of the facili	Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care					
	by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed	onnel, including but not					
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation	section, the facility must nurse to serve as a charge			F 725 Sufficient nursing staff		

Facility ID: 922999

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				PLE CONSTRUCTION		NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	G		MPLETED
		345128	B. WING			С
		545126	D. WING		(06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 725	Continued From page	- 55	F 7	25		
		te Activity of Daily Living to a		" The corrective action will b		
		hat was soiled with food left		accomplished for those residen	-	
		ast meal This affected 1 of 4		have been affected by the defic		
	sampled residents (R			practice:		
				1. Resident # 75 was assiste		
	The finding included:			care after lunch on 6/9/19 with effects to the resident.	no adverse	
i	This tag is cross refe	rred to F677:				
	Based on observatior	ns, record review, and staff				
	-	ailed to provide activities of		" The facility will identify othe		
		dependent resident who was		having the potential to be affect	ted by the	
		ver from the breakfast meal		same deficient practice:	danandant	
	-	sident the lunch meal for 1 ed for activities of daily living		1. Current residents that are with ADLS are at risk for the de		
	(Resident #75).	to for activities of daily living		practice. Upon observations no		
				residents were found to have n		
	An interview was con	ducted with the Scheduling		AM care prior to meals.		
		06/13/19 at 3:02 PM. The				
		ompleted the assignment				
		me. She added that she has				
		used to fill any open spots		" The following measures wi		
		SC stated that currently she		into place or systemic changes		
		n the facility's staff and the see. She added that they		ensure that the deficient practic	e will not	
		ancies for NAs and she very		recur: 1. Beginning on 06/19/2019	the DON/	
	-	ency NAs. The facility policy		unit managers re-educated the		
		ut 4 hours prior to their shift		and Licensed nursing staff for a		
		at most staff did not follow		outs notify the supervisor, unit		
	that policy and left the	e staff scrambling to find		and/or DON to ensure adequat	•	
	-	I that when staff called out		If unable to get coverage with f	-	
		d to find coverage either with		including prn staff, then reach o		
	the facility staff or the			agency to assist with coverage	. An admin	
		ends and holidays had more		nurse will be appointed by the	arago is	
		nore difficult to find coverage SC stated that normal		Administrator to come in if cove unsuccessful, on assisting dep	-	
		ne facility were 2 nurses and		residents with ADL s, to include		
	_	cond shift. She added that		am care after breakfast and to	-	
		the weekends as well. The		clothes are changed after meal		
		e was not aware that on		with food. Newly hired CNAS a		

Facility ID: 922999

If continuation sheet Page 56 of 70

		MEDICAID SERVICES				. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	
		345128	B. WING		(
		545120		STREET ADDRESS, CITY, STATE, ZI		14/2019
NAME OF P	ROVIDER OR SUPPLIER				CODE	
ACCORD	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLETIC DATE
F 725	Continued From page	e 56	F 7	25		
		only 4 NAs in the building.		Licensed nursing staff wi	II be educated	
		she left on Friday 06/07/19		during orientation. Any lie		
		y staffed, and she has no		CNAs that have not beer		
		ntil Monday morning. She		07/09/2019 will not be all	2	
		equested two times to have		until reeducated.		
	remote access, so sh			2. Beginning on 07/08/		
		and both times have been		coordinator will notify the	-	
		ed that it would fall to the		callouts during Monday t		
1		(WS) to handle any staffing ated that it concerned her		and the weekend superv		
		4 NAs in the building on		DON of any callouts Satu Sunday. If unable to obt	-	
		at was not enough to take		DON will notify the Admir		
		" She added that the WS		the Admin Nurse is notifie		
		all agency staff to call the		facility.		
		p if it is needed. She further		3. The facility will staff	according to the	
		ere only 4 NAs in the building		staffing pattern which is o	determined by the	
	then the Nurses and	WS should be helping on		resident acuity. The facili	ty will continue to	
	the floor and the DO	N should be made aware.		recruit and hire for open utilizing the company rec		
	An interview was con	ducted with the DON on		bonus. All call outs for nu		
	06/13/19 at 8:07 AM.	The DON stated that she		through the DON and the		
		ON since 05/13/19 and really		with replacement. Agenc		
		picture of the staffing in the		until staffing patterns are		
	facility yet. She state			reliable. The DON will be		
		MAs) were instructed to help		maintaining staffing patte		
		y have completed their		the staffing pattern sheet		
		e DON stated that if there had the ability to reach out		sheets), and documentin		
		agency for support. The		the facility is staffing account of the staffing pattern which is often account of the staffing		
		le it clear to the WS that she		resident acuity beginning	2	
		staff or the agency to get				
		t let her know so that she				
		I stated that she expected		" The facility plans to	monitor its	
		taff to meet the needs of		performance to make sur		
	each of the residents			are sustained;		
				1. The Director of nurs		
	An interview was con			the results of staffing pat		
		14/19 at 3:04 PM. The		quality assurance perform		
	Administrator stated	that if there were only 4 NAs		(QAPI) monthly for 3 mor	nths for any	

Facility ID: 922999

If continuation sheet Page 57 of 70

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE). 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	LETED
						С
		345128	B. WING		06/	14/2019
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 725	Continued From pag	e 57	F 725			
	in the building on 06/	09/19 the WS should have		recommendations or modifications	. The	
		get some help in the facility		QAPI committee can modify this pl		
		e to find some help then she I out to the DON and herself,		ensure a facility remains in complia	ance.	
		naking sure the residents				
	were taken care of.					
				" Date of compliance July 9, 20	19	
	Posted Nurse Staffin	-	F 732			7/9/19
5	CFR(s): 483.35(g)(1))-(4)				
	§483.35(g) Nurse St					
		equirements. The facility				
		ng information on a daily				
	basis: (i) Facility name.					
	(ii) The current date.					
		and the actual hours worked				
		gories of licensed and				
	resident care per shi	taff directly responsible for ft [.]				
	(A) Registered nurse					
	(B) Licensed practica	al nurses or licensed				
		s defined under State law).				
	(C) Certified nurse at (iv) Resident census					
	§483.35(g)(2) Postin	g requirements.				
		ost the nurse staffing data				
	specified in paragrap daily basis at the beg	oh (g)(1) of this section on a				
	(ii) Data must be pos					
	(A) Clear and readab	ble format.				
		ace readily accessible to				
	residents and visitors	3.				
	§483.35(g)(3) Public	access to posted nurse				
	staffing data. The fa	cility must, upon oral or				
	written request, mak	e nurse staffing data				

Facility ID: 922999

If continuation sheet Page 58 of 70

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	/ILLE		STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 732	Continued From page available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on observation facility failed to post the information on weeke Findings included: An observation on 06 the initial tour of the fa staffing was located of Director of Nursing (D Friday 06/07/19. During a telephone in AM, the weekend Nur had not been told who posting the daily staffin An interview on 06/13 DON revealed the Sc	e 58 c for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced is and staff interviews the ne required daily staffing nds for 2 of the prior 7 days. /09/19 at 10:15 AM during acility revealed the posted in the wall next to the DON) office and was dated terview on 06/12/19 at 9:22 sing Supervisor stated she o was responsible for	F 73	DEFICIENCY)	nd to g of a. dents the	
	stated she was not su posting the daily staff further stated she did communicated with w daily staffing. An interview on 06/13 Scheduling Coordinat	who was responsible for ing on the weekends. She not know if anyone had eekend staff to post the 1/19 at 3:00 PM with the for revealed she had just eduler in April 2019. She		 The following measures will be p into place or systemic changes made ensure that the deficient practice will recur: 1. Licensed staff will be re-educated 07/03/2019 by the Director of nursing checking the daily posting of nurse 	to not d on	

Facility ID: 922999

If continuation sheet Page 59 of 70

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 0 FORM AF OMB NO. 09	PROVE
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345128	B. WING		C 06/14/2	2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT STATES	XIII E		520 VALLEY STREET		
ACCORDI	US REALIN AT STATES			STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) OMPLETION DATE
F 732	because she did not explained she complet from the weekend wh Monday morning and numbers to the Admin not know who was su staffing on the weeke her who was suppose weekends. She furth- had not been posted taken the job as Sche and as far as she kne not been done on we company took over of she thought it would duty to do that, but it with her. An interview on 06/14 Administrator revealed post the daily staffing which included week expectation for the w	d the daily staffing through Friday each week	F 73	 staffing form, each shift to ensure census, licensed and unlicensed are correct. Newly hired licensed be educated during orientation. A licensed staff not educated by 07 will not be allowed to work until reeducated. Beginning 07/08/2019 the dastaffing form from prior day will be reviewed daily by Director of Nurs coordinators/ scheduler or weekers supervisor to ensure accurate car were posted for licensed and unlit staff to ensure regulatory complia DON will review the daily staffing daily for the previous day, and the weekend RN Supervisor will revie and Saturdays for four weeks the a week for 2 weeks, then weekly weeks, then monthly for 1 month. The facility plans to monitor if performance to make sure that seare sustained; Copies of the daily nurse stat posting will be submitted to the Q Assurance Performance Improve committee by the staffing coordin monthly for 3 months, for recommendations or modification compliance is achieved. 	hours staff will Any 709/2019 aily e sing/ unit end re hours iccensed ance. The form e ew Friday en 3 times for 2	
	7(02-00) Previous Versions Oh	solata Event ID: 154X1		Date of compliance July 9, 2	019	

Facility ID: 922999

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	ING			C
		345128	B. WING			06/	14/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Free from Unnec Psy CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medication	chotropic Meds/PRN Use e)(1)-(5) pic Drugs. hotropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that ints who have not used e not given these drugs is necessary to treat a diagnosed and documented ints who use psychotropic dose reductions, and ns, unless clinically effort to discontinue these	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	are limited to 14 days §483.45(e)(5), if the a prescribing practitione	ders for psychotropic drugs . Except as provided in ttending physician or					

Facility ID: 922999

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '				LETED
						(C
		345128	B. WING			06/	14/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE		5	20 VALLEY STREET		
				S	TATESVILLE, NC 28677		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION	F	(X5) COMPLETION
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		DATE
					DEFICIENCY)		
F 758	Continued From page	e 61	F	758			
		or she should document their					
		ent's medical record and					
	indicate the duration f	for the PRN order.					
	\$483 45(e)(5) PRN o	rders for anti-psychotic					
	drugs are limited to 1						
	renewed unless the a						
		er evaluates the resident for					
	the appropriateness of						
		is not met as evidenced					
	by: Based on record revi	iew and interviews the			F 758 Free from Unnecessary		
		a baseline Abnormal			Psychotropic Meds/PRN Use		
	-	t Scale (AIMs) assessment					
	for a resident who rec				The corrective action will be		
		sampled residents reviewed			accomplished for those residents found	d to	
	for unnecessary med	ications (Resident #84).			have been affected by the deficient		
	The findings included				practice: 1. Resident #84 had an AIMS completed and the second se	otod	
					on 06/10/2019 by the unit manager	eleu	
	Resident #84 was ad	mitted to the facility on					
		ses which included anxiety					
	and pseudobulbar aff	ect.			The facility will identify other reside		
					having the potential to be affected by the	ne	
		84's admission Minimum ssment dated 05/22/19			same deficient practice: 1. An audit was completed on		
	revealed, his cognitio				06/10/2019 by the director of nursing o	n	
		c medication during the			current residents receiving antipsychot		
	assessment period.	G			medications. 100% of residents receivi		
					antipsychotic medications had Abnorm		
	Review of Resident #	-			involuntary movement (AIMS) complete	ed	
		e received an antipsychotic			by July 5, 2019		
		or management. The goal adverse side effects of the					
		nonitoring for side effects of					
		ch included performing an			The following measures will be pu	t	
	AIMS assessment, a				into place or systemic changes made t		
	extrapyramidal sympt				ensure that the deficient practice will n	ot	
	condition often cause	d by using antipsychotic			recur:		

Facility ID: 922999

If continuation sheet Page 62 of 70

		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	DATE SURVEY
						С
		345128	B. WING			06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 758	Continued From page	e 62	F 75	58		
	medications.			1. On 07/03/2019 the D)irector of nursing	
				re-educated the licensed	•	
	Review of the physici	ian orders dated 05/15/19 for		and when to complete an	AIMS on	
		ed, an order for Seroquel, an		residents taking anti-psyc	chotic	
		tion, 75 milligrams by mouth		medications. Newly hired	•	
	twice a day.			staff will be educated dur		
				Licensed nursing staff that		
	-	Recommendations dated recommendation for an AIMS		educated will not be allow 07/09/2019 until reeduca		
	assessment to be co			2. Beginning on 07/08/2		
		inpicted.		be responsible for comple		
	Review of Resident #	#84's medical record		line AIMS for residents or		
	indicated there had n			medications within 48 ho		
	assessment complete	ed for Resident #84.		3. Beginning 07/08/201		
	-			be monitored in the daily	clinical meeting	
		AM during an interview with		for new antipsychotic me		
		VI) #1 she explained, she		and documented on the l	og by the UM.	
		IS assessment automatically				
		the admission assessments				
		s but stated if it was not, the		The feeility plane to a	a a a ita a ita	
		uld manually upload the		The facility plans to r		
	she completed the M	r the nurses to complete as		performance to make sur are sustained;		
				1. On 07/08/2019 the d	lirector of nursing	
	Interview with the MD	DS Coordinator on 06/14/19		will audit all residents rec	0	
		l, she did not set up any		antipsychotics monthly fo		
		ay have been missed during		ensure that AIMS are bei		
		ssion which included the		timely		
		The MDS explained, she did		2. The Director of nursi		
	not audit the medical	-		the results of the audits to	· ·	
	assessments as she	completed the MDS		assurance performance of		
	assessments.			(QAPI) monthly for 3 mor		
	During an interview w	vith the Pharmacy Consultant		recommendations or mod QAPI committee can mod		
	-	PM she explained, she		ensure a facility remains		
		B4's medical record when				
	she was at the facility					
	-	e recommended a baseline		Date of compliance	July 9, 2019	
		e conducted due to Resident			, ,	

Facility ID: 922999

If continuation sheet Page 63 of 70

		D HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/09/2019 FORM APPROVED //B NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		B) DATE SURVEY COMPLETED
		345128	B. WING			C 06/14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
ACCORDI	US HEALTH AT STATES	/ILLE		20 VALLEY STREET		
				STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 758	Continued From page	63	F 758			
	#84 being on an antip Pharmacy Consultant recommendation to th after her visits, but the been completed.	sychotic medication. The stated she emailed her le Director of Nursing (DON) e recommendation had not				
F 842 SS=D			F 842			7/9/19
	(i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a co agrees not to use or c	lease information that is o an agent only in ntract under which the agent lisclose the information ne facility itself is permitted cords.				
	professional standard	s and practices, the facility al records on each resident				

Facility ID: 922999

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345128	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	 (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The facial information contair regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic watch a serious threat to heal by and in compliance §483.70(i)(3) The faciare record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yeal legal age under State 	ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, <i>v</i> iolence, health oversight administrative proceedings, tooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident;	F	842			

Facility ID: 922999

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/09/201 1 APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	(X3) DATE SURVEY COMPLETED C			
		345128	B. WING				, 14/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
ACCORDI	US HEALTH AT STATES	VILLE			0 VALLEY STREET FATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From page	e 65	F i	842			
	(iii) The comprehensi provided;	ve plan of care and services					
	and resident review e						
		s, and other licensed					
	professional's progres	ss notes; and logy and other diagnostic					
		equired under §483.50.					
		is not met as evidenced					
	by:	iow and staff interviews the			F 842 Resident Records – Identifiable		
		iew and staff interviews the nent an assessment for a			Information	;	
	-	or a resident who was sent			mornation		
	-	hange in condition (Resident			The corrective action will be		
	#34). The facility also	o failed to document pulse			accomplished for those residents foun	d to	
		s for a resident who received			have been affected by the deficient		
		6). This affected 2 of 2			practice:		
		lical records were reviewed			1. Resident # 34 had an assessmen	t	
	for hospitalization.				completed for change in condition on 6/14/2019.		
	Findings included:				 Resident #86 is no longer in facilit was discharged on 06/10/2019 	ty	
	11/05/18 with diagnos						
		seizures, Alzheimer's			• The facility will identify other resid		
		mentia, depression and			having the potential to be affected by t	he	
	anxiety.				same deficient practice:1. Current residents that have a cha	nge	
	A review of a care pla	an with a revised date of			in condition have the potential to be	iye	
		esident #34 was at risk for			affected. The 24-hour report will be		
					reviewed daily by the DON/UM/Superv	visor	
		ased mobility, history of falls		1	Teviewed daily by the Delty on Superv		
	falls related to decrea and a history of seizu	ased mobility, history of falls ire activity. The goal			to identify any change of condition to		
	falls related to decrea and a history of seizu indicated Resident #3	ased mobility, history of falls ire activity. The goal 34 would be free from injury			to identify any change of condition to ensure proper notification and		
	falls related to decrea and a history of seizu indicated Resident #3 from falls and the inter	ased mobility, history of falls ire activity. The goal 34 would be free from injury erventions were listed in part			to identify any change of condition to ensure proper notification and assessments has been completed.		
	falls related to decrea and a history of seizu indicated Resident #3 from falls and the inte to anticipate and mee	ased mobility, history of falls are activity. The goal 34 would be free from injury erventions were listed in part at the resident's needs,			to identify any change of condition to ensure proper notification and assessments has been completed.All residents receiving oxygen has	/e	
	falls related to decrea and a history of seizu indicated Resident #3 from falls and the inte to anticipate and mee	ased mobility, history of falls ire activity. The goal 34 would be free from injury erventions were listed in part			to identify any change of condition to ensure proper notification and assessments has been completed.	/e	

Event ID: 154X11

Facility ID: 922999

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
					С
		345128			06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORD	IUS HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETIO
F 842	Continued From page	e 66	F 842		
	A review of the most Data Set (MDS) date Resident #34 was co decision making. The Resident #34 require activities of daily livin supervision with eatin A review of an incide 6:00 PM indicated Re down on the floor arc wheelchair in the dini revealed Resident #3 right eyebrow and 2 I of the bridge of his no revealed family arrive for Resident #34 to b A review of a Nurse's 05/30/19 at 6:40 PM	recent quarterly Minimum d 04/05/19 revealed gnitively intact for daily e MDS also revealed d limited assistance for g except he only required ng. nt report dated 05/30/19 at esident #34 was lying face bund 5:53 PM in front of his ing room. The report 84 had a laceration above his lacerations on the right side ose. The report further ed at 7:15 PM and requested re sent to the hospital.		 daily clinical meeting starting 7/8 and by the supervisor S-S to ensoxygen orders are in place. Documentation of this review will completed daily and kept by the addition rounds are completed dastarting 7/8/19 by the DON/UM/S to ensure that each resident recersoxygen has a physician order. Documentation of the rounds will by the DON. 4. DON/UM/Supervisor will rev previous 24hr progress notes to determine if a change of condition documented and to ensure if an assessment was completed and notifications of RP and MD were completed. Documentation of this will be kept by the DON on a log 	ure I be DON In aily Supervisor siving I be kept iew the n is if
	Nurse's progress not assessment document family expressed com and requested he be A review of a hospita 05/30/19 at 10:36 PM been transported to t 05/30/19. The document reported Resident #3 a wheelchair and the noted that Resident # drawn, and his leg was was indicative of his a further indicated family	I history and physical dated I revealed Resident #34 had		 The following measures will into place or systemic changes in ensure that the deficient practice recur: Beginning on 06/19/2019 th unit managers re-educated the C Licensed nursing staff on docum including change of conditions in residents, notifying MD and Resp Party of change in condition, and oximetry percentages on resident receiving oxygen. Newly hired C Licensed nursing staff will be edu during orientation. Any licensed re-educated by 07/09/2019 will n allowed to work until the re-educ 	nade to will not CNAs and entation, ponsible I pulse ts NAs and ucated staff not ot be

Facility ID: 922999

If continuation sheet Page 67 of 70

		MEDICAID SERVICES	(X2) MI II TIP	LE CONSTRUCTION	(X3) DATE S	<u>. 0938-03</u> SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPL	
			/			
		345128	B. WING			, 14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
E 040	Continued From non	- 67				
F 842			F 84			
		oad-spectrum antibiotics had		2. Beginning on 07/08/2019 the		
		picion of a urinary tract		managers/supervisors will conduct audit to review documentation 5 x		
		eakthrough seizure and blood sugar). The report		for 12 weeks to ensure that reside		
		dent #34 had a high blood		have a change of condition or requ		
		and he was treated in the		pulse oximetry checks have been		
		n intravenous fluids and		documented accurately. Finding v	vill be	
	insulin with improvem			given to the DON daily.		
		5		3. New orders will be reviewed in	n the	
	During an interview o	n 06/13/19 at 9:27 AM,		daily clinical meeting starting 7/8/1	9 M-F	
		vhen a resident had a		and by the supervisor S-S to ensu	re	
	-	Nurses were expected to call		oxygen orders are in place.		
		cument the change in		Documentation of this review will b		
	condition in the reside	ent's medical record.		completed daily and kept by the D		
	During a talanhana in	ton iow on 06/12/10 at 0:52		addition rounds are completed dai	-	
		nterview on 06/13/19 at 9:52 med she worked on second		starting 7/8/19 by the DON/UM/Su to ensure that each resident received		
		d recalled Resident #34's fall		oxygen has a physician order.	/ing	
		She explained she called		Documentation of the rounds will b	ne kent	
		to inform them of the fall		by the DON.		
	-	ter 3 family members came		4. DON/UM/Supervisor will revie	ew the	
		ted Resident #34 was not		previous 24hr progress notes to		
	-	wanted him sent to the		determine if a change of condition	is	
		she called the on-call		documented and to ensure if an		
		to send Resident #34 to the		assessment was completed and if		
		he family request. She		notifications of RP and MD were	.	
		d assessed Resident #34		completed. Documentation of this	review	
		hospital, but she did not		will be kept by the DON on a log		
		isident #34 because it was				
	her first night of work	eted the incident report the				
		eturned to the facility and				
	-	umented on a change in		The facility plans to monitor its	s	
	condition form and a			performance to make sure that sol		
	Resident #34 went to			are sustained;		
	couldn't recall what s			1. The Director of nursing will pr	esent	
				the results of the audits to the qua		
		n 06/13/19 at 12:30 PM, the		assurance performance committee		
	Director of Nursing ve	erified there was an incident		(QAPI) monthly for 3 months for a	nv	

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/09/2019 MAPPROVEE D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		345128	B. WING			C 06/14/2019		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT STATES	VILLE		52	20 VALLEY STREET			
ACCORDI				S	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	Continued From page	e 68	F	842				
1 012		34's fall on 05/30/19 but		042	recommendations or modifications. TI	ne		
	•	ss notes documented and			QAPI committee can modify this plan			
	there was no change	in condition form completed			ensure a facility remains in compliance			
	•	being sent to the hospital.						
		d have expected to see a						
	form completed rega	e or a change in condition			Date of compliance July 9, 2019			
	· •	ng sent to the hospital.						
	÷	on 06/14/19 at 10:01 AM, Unit						
		was the expectation for the change in condition form						
	when a resident was	-						
	Administrator stated there to be a progres	on 06/14/19 at 3:04 PM, the it was her expectation for s note and a change in o a resident being sent to the						
	2. Resident #86 was 09/24/15 with diagno Alzheimer's disease, pulmonary (lung) dise anxiety.	chronic obstructive						
	Data Set (MDS) date	verely impaired in cognition king. The MDS also 36 required extensive						
		tion Administration Record gh 06/10/19 revealed there nation percentages						
	During an observatio	n on 06/09/19 at 12:14 PM						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/09/2019 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING			_		C 14/2019
NAME OF PI	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET	_		
				;	STATESVILLE, NC 2867			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page Resident #86 was lyir cannula in her nose a connected to an oxyg bed. The oxygen com liters per minute. During an observation Resident #86 was lyir cannula in her nose a connected to an oxyg bed. The oxygen com 1.5 liters per minute. During an interview of Manager #2 stated re oxygen should have of percentages checked shift and as needed. been no oxygen satur documented since 05 During an interview of Director of Nursing st that pulse oximetry per documented for Resid During an interview of Administrator stated in	e 69 ng in bed with a nasal nd the oxygen tubing was en concentrator next to her iccentrator was turned on to 2 n on 06/10/19 at 2:55 PM ng in bed with a nasal nd the oxygen tubing was en concentrator next to her iccentrator was turned on at n 06/12/19 at 2:26 PM, Unit sidents who required oxygen saturation and documented every She confirmed there had ation percentages /17/19 for Resident #86. n 06/13/19 at 12:38 PM, the ated it was her expectation ercentages should be ft. She further stated pulse should have been dent #86. n 06/14/19 03:04 PM, the t was her expectation for ntages to be documented for		842]			

Facility ID: 922999

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		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE NO. 0938-039
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345128	B. WING			R-C 6/14/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/14/2019
				520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	SVILLE		STATESVILLE, NC 28677		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COP	RRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
F 000	INITIAL COMMENTS	5	F 00	00		
	Service Regulation, I	The Division of Health Nursing Home Licensure and ed an on-site revisit. The f complainace.				
{F 656} SS=D	-	Comprehensive Care Plan	{F 65	5}		7/8/19
		cility must develop and				
	care plan for each re resident rights set for	hensive person-centered sident, consistent with the rth at §483.10(c)(2) and				
	medical, nursing, and	ames to meet a resident's d mental and psychosocial				
	assessment. The condescribe the followin					
	or maintain the resid physical, mental, and	are to be furnished to attain ent's highest practicable d psychosocial well-being as				
	(ii) Any services that under §483.24, §483	.24, §483.25 or §483.40; and would otherwise be required 9.25 or §483.40 but are not				
	under §483.10, inclu treatment under §48					
	rehabilitative service provide as a result of					
		a facility disagrees with the RR, it must indicate its ent's medical record.				
	resident's representa	th the resident and the ative(s)- pals for admission and				
	desired outcomes.					

Electronically Signed

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.

07/04/2019

	-	ND HUMAN SERVICES			PRINTED: 07/09/20 FORM APPROVE OMB NO. 0938-03
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345128	B. WING		06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET	
//0001121				STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BECOMPLETIONIE APPROPRIATEDATE
{F 656}	Continued From page	e 1	(F 65	6}	
		eference and potential for	1. 00	-1	
		cilities must document			
		s desire to return to the			
	community was asse	ssed and any referrals to			
		es and/or other appropriate			
	entities, for this purpo				
		in the comprehensive care			
		in accordance with the h in paragraph (c) of this			
	section.	n in paragraph (c) of this			
		Γ is not met as evidenced			
	by:				
		ons, record review and staff		Preparation and/or executio	on of this plan
	interview the facility f			of correction does not consti	
		on-centered care plan for a		admission or agreement by	-
		elling urinary catheter		the truth of the facts alleged	
	(Resident #54) and fa	-		conclusions set forth in the s	
		vidualized care plan for a d assistance with bed mobility		deficiencies. The plan of cor prepared and/or executed so	
		uded how much staff		it is required by the provision	
		ed to care for the resident		and State law.	
		of 3 sampled residents.			
	, , , , , , , , , , , , , , , , , , ,			F 656 Develop/Implement C	omprehensive
	The findings included	1:		Care Plan	
		initially admitted to the		The corrective action wi	
	-	nd most recently readmitted		accomplished for those resid	
	to the facility on 05/1			have been affected by the de	eficient
		neuromuscular dysfunction of		practice:	mum Data Cat
	the bladder.			1. On 06/12/2019 the Mini	
	Paview of Posidort +	#54's admission assessment		nurse revised resident # 54	
	dated 02/28/19 revea			centered care plan in order t accurately reflect an indwelli	
	indwelling urinary cat			2. On 06/12/2019 the Mini	•
				nurse revised resident # 298	
	Review of the compre	ehensive Minimum Data Set		Person-centered care plan in	
		9 revealed that Resident #54		may accurately reflect the as	
	. ,	aired for daily decision		required by staff with bed mo	
		total assistance of two staff		toileting	-

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/09/201 FORM APPROVE OMB NO. 0938-039
STATEMENT C	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345128	B. WING		R-C 06/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•
				520 VALLEY STREET	
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION
{F 656}	Continued From page	e 2 g. The MDS further revealed	{F 65	6} 3. The task segment i	n Point click care
	that Resident #54 has was always incontine	d an indwelling catheter and		that communicates to th assistant was updated t 54 indwelling catheter a amount of assistance re	ne certified nursing o reflect resident # nd resident # 298
	dated 04/07/19 and s Coordinator read in p			for bed mobility and toile	•
	patent and intact. Wil	he catheter seemed to be I proceed to care plan and ion and avoid complications idwelling catheter.		The facility will ider having the potential to b same deficient practice: 1. On 07/02/2019, an residents with indwelling	audit of current
	catheter.	n for the indwelling urinary		those residents that req with bed mobility and to completed by the direct (DON) and/or unit many	uire assistance ileting was or of nursing ger to ensure that
	06/09/19 at 3:31 PM. bed with her eyes op	sident #54 was made on Resident #54 was resting in en and was alert and verbal. have an indwelling urinary		a residents person -cen accurately reflects indw and the amount of staff required with bed mobili	velling catheters assistance
		ining clear yellow fluid into a ntained approximately 300 lear yellow fluid.			
		ducted with the MDS /19 at 2:30 PM. The MDS d that no care plan had been		The following meases into place or systemic c ensure that the deficien recur:	hanges made to
	catheter. She could n care plan for the indw	ent #54's indwelling urinary lot explain why there was no velling urinary catheter but oversight on her part. The		1. On 07/02/2019 the Consultant will provide a IDT (Interdisciplinary Te includes the MDS Coord	re-education to the am) which
	MDS Coordinator sta	ted that she should have an for the indwelling urinary		Worker, Activities Direct Therapy Director and N Management of the dev Person -centered comp	tor, Dietary, ursing relopment of
	Nursing (DON) on 06	ducted with the Director of /13/19 at 8:10 AM. The DON ted indwelling urinary		plans. Ongoing, newly IDT staff will receive edu their orientation period b	hired MDS and ucation during

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		IO. 0938-039 E SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	. ,		CON	IPLETED
						R-C
		345128				6/14/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
{F 656}	Continued From page	e 3	{F 656	5}		
	catheters to be care	planned as part of the		MDS Consultant		
	comprehensive care			2. The Regional MDS		
				review and audit 3 com		
		s initially admitted to the		-centered comprehens		
		nd most recently readmitted ht #298's medical diagnoses		weekly for 12 weeks to		
		hemiplegia, above knee		plan reflects an indwell present and the amour		
	amputation of lower			assistance that is requi		
				and toileting.		
	Review of a care plar	n that was initiated on				
		, Resident #298 has an				
	Activity of Daily Living					
		elated to right above knee		The facility plans t		
		range of motion, and right niparesis. The goal of the		performance to make s are sustained;	sure that solutions	
		dent #298 will improve		1. the Administrator v	will report the results	
		on in ADLs through the		of the audits to the Qua	-	
		rventions included: BED		Performance Improven	-	
		ent requires staff assistance,		The Quality Assurance	and Performance	
	DRESSING: the resid			Improvement Committe		
		IAL HYGIENE: the resident		audits to make recomn		
		nce, and TOILETING: the		ensure compliance is s		
	resident requires staf	assistance.		and determine the nee auditing beyond the th		
	Review of the quarter	rly Minimum Data Set (MDS)				
		aled that Resident #298 was				
		for daily decision making		Date of complianc	e July 8, 2019	
		ve assistance of two person				
	-	eting, and personal hygiene.				
		ealed that Resident #298				
	assessment.	alls since the previous				
		note dated 05/03/19 at 7:59				
		sing Assistant (NA) #2				
		#298 was on the floor. He NA #2 was turning him to				
		observed resident on the				
		bedside mat. Blood under				

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	N IDENTIFICATION NUMBER: A.		ING		COMPLETED	
		345128	B. WING				-C
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	14/2019
	US HEALTH AT STATES	/11 E			520 VALLEY STREET		
ACCORDI	US REALIN AT STATES				STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Continued From page	2 4	{F 6	656	3		
	head and laceration w	vith large amount of blood. oom (ER) for evaluation.					
	06/11/19 at 1:49 PM. 05/03/19 Resident #2 by NA #2 to provide in turned onto his side h floor. Nurse #2 stated sustained a head inju She added that she w Resident #298 and th she had cared for him not aware of how man turn him in bed or to p relied on the NAs to k #2 confirmed she was information in Reside stated if she had any	ry and was sent to the ER. vas not familiar with at night was the first night h. She stated that she was my staff members it took to provide incontinent care and know that information. Nurse is not aware of the nt #298's care plan but question about how much at he needed she would					
	Coordinator reviewed and stated that she co assistance he require incontinence care. Sh the care plan to conta care for the resident b the policy of the facilit An interview was com Nursing (DON) on 06.	 (19 at 4:41 PM. The MDS Resident #298's care plan ould not tell how much d for bed mobility or he stated that she expected ain enough information to but would also depend on ty. ducted with the Director of (13/19 at 8:16 AM. The DON 					
	how much staff assist	ot contain the information of					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/09/2019 FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		R-C 06/14/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
{F 656}	facility. The DON stat plan to have sufficien care staff could safely #298.	a systemic breakdown in the ted she expected the care t information, so the direct y take care of Resident	{F 6	56}	
{F 690} SS=D	CFR(s): 483.25(e)(1) §483.25(e) Incontinent §483.25(e)(1) The factor resident who is continent admission receives as maintain continence of condition is or become not possible to maintat §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who entri- indwelling catheter is resident's clinical com- catheterization was no (ii) A resident who entri- indwelling catheter or is assessed for remov- as possible unless that demonstrates that car and (iii) A resident who is receives appropriate prevent urinary tract in continence to the exter §483.25(e)(3) For a re- incontinence, based of	nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical les such that continence is ain. esident with urinary on the resident's asment, the facility must ters the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.	{F 69	90}	7/8/19

Facility ID: 922999

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STATEMENT (CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			<u>O. 0938-039</u> e survey IPLETED R-C
		345128	B. WING				5/14/2019
	ROVIDER OR SUPPLIER	VILLE	1	52	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET TATESVILLE, NC 28677	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 690}	receives appropriate restore as much norm possible. This REQUIREMENT by: Based on observation interview the facility furinary catheter tubin pulling for 1 of 2 resid indwelling catheters (The findings included Resident #54 was ini on 02/28/19 and most facility on 05/14/19. F included neuromuscu bladder. Review of the compre- (MDS) dated 04/01/1 was moderately impa- making and required members with toiletin that Resident #54 ha was always incontine An observation of Re 06/09/19 at 3:31 PM. bed with her eyes op She was observed to catheter that was dra collection bag that co	 It who is incontinent of bowel treatment and services to nal bowel function as It is not met as evidenced It is not met as evidenced It is not met as evidenced with urinary (Resident #54). It is inclusted to the facility service admitted to the facility readmitted to the facility service admitted to the facility service admitted to the facility service admitted to the facility of recently readmitted to the facility service admitted to the facility service admitted to the facility for the facility readmitted to the facility for the facility readmitted to the facility of the facility is the facility is the facility is the facility readmitted to the facility for the facility is the f	{F 6	590}	 F 690 Bowel Bladder Incontinence Catheter UTI The corrective action will be accomplished for those residents found have been affected by the deficient practice: Resident # 54 indwelling catheter was secured on 06/14/2019to prevent tugging or pulling The facility will identify other reside having the potential to be affected by the same deficient practice: On 06/14/2019 the DON and/or un manager conducted a visual audit of current residents with indwelling cathet to ensure they are secured. Any finding of un secured indwelling catheters will secured immediately. The following measures will be put into place or systemic changes made to ensure that the deficient practice will n 	ents he nit ters gs be t	
	secured to Resident be pulled across the	heter was not anchored or #54's leg and was noted to			recur: 1. Beginning on 06/19/2019 the licensed nursing staff and the CNA's w be re-educated by the DON on the poli and procedures for proper		

Facility ID: 922999

		ND HUMAN SERVICES					FORM APPROV B NO. 0938-03
	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED		
		345128	B. WING _				R-C 06/14/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				520	VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		ST	ATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
{F 690}	Continued From page	e 7	{F 69	303			
. ,	on the side of the bee or discomfort at this t	d. Resident #54 denied pain ime.	Į, ot		anchoring/securing of catheter tubingNew employees will receive this education during orientation.		
	06/10/19 at 11:29 AW in bed with her eyes of indwelling urinary cat yellow fluid into a dra side of the bed. The i was not anchored or leg and again was pub brief and connected t side of the bed. Resid discomfort but not sp urinary catheter. An observation of Re 06/11/19 at 8:08 AM. bed with her eyes op urinary catheter was The indwelling urinar or secured to Reside	theter was draining clear inage bag hanging on the indwelling urinary catheter secured to Resident #54's illed across the front of her to the drainage bag on the dent #54 verbalized general ecific to her indwelling esident #54 was made on Resident #54 was resting in en. Resident #54's indwelling draining clear yellow fluid. y catheter was not anchored nt #54's leg and was running ief into the collection bag			 The facility plans to monitor its performance to make sure that soluti are sustained; 1. The DON and/or Unit manager w conduct weekly visual audits for 12 w of all indwelling catheters to ensure compliance with anchoring of tubing 2. The Director of nursing will prese the results of the audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. T QAPI committee can modify this plane ensure a facility remains in compliance Date of compliance July 8, 2019 	vill veeks ent The to ce.	
	06/12/19 at 12:03 PM in bed with her eyes of urinary catheter that y to her leg. The indwe pulled up over the sic connected to the drai side of the bed. The of yellow fluid and Resid complaints.						
	. ,	ducted with Nursing 06/12/19 at 1:38 PM. NA #3 as caring for Resident #54					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	(X3) DATE COMF	
		345128	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORDI	US HEALTH AT STATES	/ILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 690}	that she performed ca emptied the catheter nurse how much outp stated that the nurse anchoring or securing she would have notice was not anchored or notified the nurse. NA not noticed that Reside was not anchored and it to the nurse. An observation of Res with Nurse #3 were co 2:11 PM. Resident #5 her eyes open. Her in was pulled through th pulled across the from to the drainage bag h bed. Nurse #3 confirm urinary catheter tubin pulling across the from She stated that all inco should be anchored to responsibility of the n anchored appropriate would immediately ar An interview was con on 06/12/19 at 2:19 P that it would be a goo the indwelling urinary #54's leg. She added fed through her brief a of the bed to ensure i not pull and cause dis	her needs. NA #3 stated atheter care every day, bag, and reported to the out Resident #54 had. She	{F (690}			

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 07/09/2019 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	E SURVEY PLETED
		345128	B. WING				R-C / 14/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
ACCORDI	US HEALTH AT STATES	VILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 690}	confirmed that Nurse anchoring or securing catheter tubing for Re that she expected the tubing to be secured or tugging on the resi An interview was con Administrator on 06/1 Administrator stated t	 /13/19 at 8:10 AM. The DON #3 would be responsible for g the indwelling urinary esident #54. The DON stated e indwelling urinary catheter at all times to prevent pulling dent. ducted with the 4/19 at 3:04 PM. The that she expected indwelling anchored or secured at all	{F (690}			

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