STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted from 12/3/20 to 12/10/20. The survey team returned to the facility on 12/17/20 to obtain additional information. Therefore, the exit date was changed to 12/17/20. Three of the seven allegations were substantiated. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 as a scope and severity of J CFR 483.24 at tag F678 as a scope and severity of K The tag F600 and F678 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/17/20 and was removed on 12/9/20. An extended survey was conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		1/13/21

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

Electronically Signed | 01/08/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, family, and physician interviews, and record review the facility failed to notify the physician and family of a resident's decline in physical and mental status for 1 of 3 residents reviewed for a change in condition. (Resident #2)	F 580	Address how corrective action will be accomplished for those residents found to be have been affected by the deficient practice. This resident #2 was discharged to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 Findings included: Resident #2 was admitted to the facility on 3/20/2020. Resident #2's minimum data set assessment dated 10/21/2020 revealed he was assessed as severely cognitively impaired. He had no moods or behaviors. He required extensive assistance with bed mobility, transfers, eating, and toilet use. His active diagnosis included medically complex conditions, Alzhiemer's Disease, heart failure, hypertension, chronic kidney disease stage 5, diabetes mellitus, dementia, anxiety disorder, depression, and respiratory failure. Resident #2's care plan dated 10/20/2020 revealed he was care planned for an activities of daily living self-care performance deficit related to weakness, dementia, poor posture, needing of cues to improve poster, decreased problem solving skills and unsteady gate. The interventions included to discuss with the resident/family/Power of Attorney any concerns related to loss of independence, decline in function. Monitor/document/report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, or declines in function. A nursing note dated 10/27/2020 revealed Resident #2 was documented to have weight loss of 4 1/2 pounds that month. He was recently diagnosed and now recovering from COVID. Staff stated his appetite was now improving and he was doing well. Resident #2 was feeding himself when the nurse assessed that day. The primary care provider was aware as well as the	F 580	hospital on 11-14-20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who has a significant change in the resident□s physical, mental, or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Records were reviewed to include most recent vital signs and intake for the previous 48 hours by the Director of Nurses to determine if the responsible party, resident, physician and if necessary, the medical were notified of significant changes in condition. No residents were identified as being affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Licensed staff to include all agency staff were educated on 1-8-21 regarding the need to notify the physician and family of a resident who has a significant change in physical, mental, or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) by the Director of Nurses or designee utilizing the policy and procedure for notifications. Newly hired employees to include agency will be educated during orientation regarding the facility Notification process to include the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 responsible party. A physician' s note dated 11/2/2020 revealed Resident #2 was reviewed by the physician. The physician documented Resident #2 was stable and to continue current plan of care at that time. Resident #2's daily fluid intake records on 11/12/2020 and 11/13/2020 revealed he had no reported fluid intake on those days. A progress note dated 11/13/2020 at 6:37 PM, written by Nurse #5, revealed Resident #2's Ativan was held due to the resident not being rousable. A progress note dated 11/13/2020 at 9:10 PM, written by Nurse #6, revealed the nurse noted the previous nurse reported Resident #2 was noted to be lethargic. The nurse aide reported Resident #2 had a poor appetite and was pocketing food in his mouth. During assessment the nurse noted Resident #2 to be lethargic and not his usual norm. He had less mobility and the nurse notified the physician of the change in status. A new order was given to obtain labs and urinalysis. The responsible party was notified of the change in condition and new orders from the provider. A progress note dated 11/13/2020 at 9:19 PM, written by Nurse #6, revealed the responsible party was called and voiced concern about Resident #2 and requested he be sent to the emergency room. The physician was notified, and an order was obtained to discharge Resident #2 to the hospital for evaluation and to discontinue orders for labs. The resident #2's physician's orders dated	F 580	need to notify the physician and family of a resident who has a significant change in physical, mental, or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Clinical medical record review for each previous 24-hours will be brought to the daily clinical meeting by the unit manager. Records will be reviewed by the Clinical Team to include Unit Manager, Director of Nursing, Social Services, Rehabilitation to ensure notification of physician and family for significant changes has been completed. The minutes from the meeting will be reviewed by the Director of Nurses 3 times per week for 4 weeks then weekly for 4 weeks, then monthly for 1 month. The Administrator will review and initial the daily clinical minutes weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the clinical minutes tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

11/13/2020 revealed Resident #2 was ordered to be sent to the emergency room for evaluation.

The hospital admission record dated 11/14/2020 at 12:55 revealed Resident #2 did not present in acute distress, stated he felt fine, and was documented to be "not ill appearing." He did not have a temperature; however, he had a change in mental status and had not been eating for the past 2 days reported from the facility. Following labs, the primary diagnosis was severe sepsis due to a urinary tract infection.

During an interview 12/7/2020 at 1:47 PM Nurse #7 stated on 11/11/2020 when she took care of Resident #2 from 7 PM to 7 AM, he did not have an altered mental status. She stated she was unsure what he was like before he had COVID-19 but following his COVID-19 recovery he was very disoriented. She stated when she got report there was no mention of him having poor fluid intake the shift prior.

During an interview on 12/8/2020 at 10:45 AM Nurse Aide #5 stated on 11/12/2020 she took care of Resident #2 from 3 PM though 11 PM. She further stated on that day he had no fluid intake despite her trying to get him to drink a shake as well as giving him multiple options for fluids. She stated he just was not "having it" that day and he was more lethargic so she let Nurse #5 know about his lack of fluid intake. She did not know what was done with the information after she passed it along to the nurse as she had other residents to attend to.

During an interview on 12/8/2020 at 8:39 AM Nurse Aide #4 stated she did work on 11/12/2020 on Resident #2's hall but she was agency staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

and could not remember him clearly. She concluded due to her being agency staff, she did not know if he had a change in condition during her shift but if he had not taken and fluids she would have let her nurse know, but she did not remember if she did or who the nurse was.

During an interview on 12/7/2020 at 12:23 PM Nurse Aide #5 stated she took care of Resident #2 on 11/13/2020 from 7 AM and worked a double through 11 PM. She further stated she let Nurse #5 know Resident #2 was not eating or drinking despite multiple efforts to get him to take fluids. She further stated Resident #2 usually drank well. She concluded she did not know what Nurse #5 did with the information, but when Nurse #6 took over at 7 PM Nurse Aide #5 again told Nurse #6 of her concern and that was when Resident #2 was sent to the hospital.

During an interview on 12/8/2020 at 8:44 AM Nurse #5 stated she did not know Resident #2's baseline, but he was too drowsy to give something that would make him drowsier, so she held the Ativan on 11/13/2020. She stated she could not remember notifying anyone, but she did hold the Ativan and let the oncoming nurse know. Nurse #5 said Resident #2's hall had people moving on and off all the time and it was chaos so she could not remember notifying the physician or family. Nurse #5 reiterated because of the chaos of the residents being moved as well as not having a history with Resident #2 she did not notify the physician or family. She continued to state no one mentioned to her that he had not taken any fluids on 11/12/2020 and 11/13/2020 and she was not aware of the fluid intake of Resident #2. She stated she could not recall any nurse aide informing her of the fact he had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

been eating or drinking 11/12/2020 and 11/13/2020.

During an interview on 12/8/2020 at 8:09 AM Nurse #6 stated she came in to work at 7 PM on 11/13/2020. She stated she had not worked for a few days and Resident #2 had been at his baseline. She stated Nurse #5 told her Resident #2 was weak and drowsy, so she had with-held his medicine. She stated when there was a change in condition the physician and the family should be made aware of the change and she was concerned that Nurse #5 had not notified anyone. She stated Nurse Aide #5 also told her Resident #2 had not eaten or taken fluids in the last two days. She stated she then assessed him and got the doctor to order labs and then she called the family to inform them. She stated the family requested Resident #2 be sent to the hospital, so she called the physician again and got an order to send him out. She stated Resident #2 was not at his baseline.

During an interview on 12/7/2020 at 2:40 PM Unit Manager #1 stated she did not see Resident #2 on 11/12/2020 or 11/13/2020 because she was the unit manager, not the floor nurse and no one had informed her Resident #2 appeared to have a decline on 11/12/2020 or 11/13/2020. She stated she did not have any further information for the family at that time. She stated Nurse #5 did not report any concerns to her during 11/12/2020 or 11/13/2020 about Resident #2. She further stated her shift ended and later that night Nurse #6 called her to inform her Resident #2 was being sent to the emergency room. She reported Resident #2 had not eaten that evening and she had gotten orders for labs, but the family wanted Resident #2 discharged to the hospital, so they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7	F 580		

complied. Unit Manager #1 said no staff informed her Resident #2 had very poor intake the past days, and she was unaware until this interview that Ativan was held due to his non-rousable status on 11/13/2020. She stated the nurse aides were responsible for notifying their nurses if there was a change in intake and then the nurses would inform herself, the physician, and the family. She stated if the Ativan was held due to a change in mental status, and his by mouth intake had declined, she should have been made aware by the nurses. The physician and family should also have been made aware of this change.

During an interview on 12/7/2020 at 6:53 PM the Power of Attorney for Resident #2 stated she was not told Resident #2 had a change in status. She stated that the last communication she had with the facility regarding his status was on 10/27/20 when she was told he was doing well, and his eating had improved. The Power of Attorney stated on the 11/13/20 she received a phone call from Unit Manager #1 at 5:00 PM telling her that Resident #2 had a pressure sore on his back and reddened heals. She was not told any more information at that time. On 11/13/20 after 10:00 PM a nurse called her and told her that Resident #2 had not eaten or had anything to drink for the last two day and she was very concerned about him. The nurse said she notified the physician and he ordered for STAT labs to be drawn. The Power of Attorney stated she called the nurse back and requested Resident #2 be sent to the hospital. The nurse told the complainant that she would have to ask the unit supervisor for permission to send the resident out to the hospital. The complainant stated she was concerned she had not been told earlier that Resident #2 was not eating or drinking. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 emergency room nurse told the Power of Attorney the resident was diagnosed with a urinary tract infection and sepsis. During an interview on 12/8/2020 at 9:24 AM Physician #1 stated whenever there was a change in mental status for a resident, staff should contact him if the change was different from the resident' s known baseline. He further stated he felt the staff could use their judgement with Resident #2 as he went back and forth on his abilities due to his advanced Alzheimer's disease. Physician #1 said there was no yes or no answer to the question of if staff should have notified him about Resident #2 being difficult to rouse due to his Alzheimer's disease. He further stated he was not aware Resident #2 had no fluid intake on 11/12/2020 and 11/13/2020 and it would have been good for staff to notify him of this issue. During an interview on 12/8/2020 at 10:55 AM the Director of Nursing stated it depended if staff should notify the physician and family if a resident's status changed. He stated in Resident #2's situation it would have been a good idea to notify the physician and family, so they were not surprised by his status. He further stated if there was a dip in consumption for 24 hours it was not clinically alarming generally. He stated nurse aides were responsible for informing the nurses if there were any changes in intake and the nurses would inform the physician and family. He then concluded it would have been good for Nurse #5 to notify the physician and family on the 11/13/2020 when she was made aware his status had stayed declined.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		1/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interviews, and emergency medical services interview, the facility failed to recheck the oxygen saturation levels, assess the resident, continuously monitor the resident, and initiate nursing and medical treatment for a resident with an acute change in condition for 1 (Resident #1) of 3 residents reviewed for respiratory care. Resident #1 coded and expired in the facility on 11/27/20. Immediate Jeopardy began on 11/27/20 when Nurse #1 failed to initiate an assessment after being notified by NA #1 of Resident #1 having trouble breathing with a pulse oximetry reading of 66%. Documentation on an ambulance service incident report dated 11/27/20 revealed Resident #1 died at the facility at 7:42 PM after 3 rounds of cardiopulmonary resuscitation (CPR). The immediate jeopardy was removed on 12/9/20 when the facility provided and implemented an	F 600	Address how corrective action will be accomplished for those residents found to be have been affected by the deficient practice The Resident #1 expired. Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by this deficient practice. On 12-4-20 a record review of any vital signs available was completed by the MDS nurse on all residents in the building for the previous 72 hours. Vital signs were within baseline. No areas of concerns were identified. No acute changes were identified Address what measures will be put into place or systemic changes made to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10 acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility from another facility on 11/21/20 with cumulative diagnoses some of which included Covid-19, Type 2 Diabetes Mellitus, Hypertension, Dementia, and Dysphagia. Documentation on a quarterly Minimum Data Set assessment dated 10/16/20, prior to transfer to the facility, coded the resident as alert and oriented and independent with his activities of daily living. Resident #1 was not coded as requiring oxygen therapy on the 10/16/20 MDS assessment. Documentation on the care plan, dated as initiated on 11/23/20, revealed a focus area for Covid-19 suspected/active diagnosis. One of the interventions on the care plan under the Covid-19 focus area was to monitor for any changes in condition. Documentation on the same care plan had a focus area for the advance directive of full code with a BIMS (Brief Interview for Mental Status) score indicating Resident #1 had moderately impaired cognition. Resident #1 did not have a care plan focus area for oxygen therapy. Resident #1 had a current physician's order initiated on 11/23/20 for the provision of oxygen at	F 600	ensure that the deficient practice will not recur On 12/9/20 all residents (census 102) received a respiratory assessment to ensure there are no acute change in condition by the Director of Nursing, Unit Manager and Charge Nurse. There were no acute changes in conditions identified. On 12/9/20 All nursing staff to include agency were in-serviced regarding the initiation of nursing and medical treatment with acute changes to include but not limited to change in vital signs, level of conscientious, etc. by either the Administrator or Director of Nursing. This will ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is change requiring notification. Discussion topics included accuracy of vital signs; acute changes from baseline; carefully listening to the patient and asking for assistance if indicated; how to get in touch with another nurse or administrative staff outside of business hours. Each nursing station is equipped with a "step process", a system which provides guidelines for what to do in the event of but not limited to falls with significant injury, equipment malfunction, elopement etc. which are guidelines on how to handle incidents and provides contact information and contact information for the Administrator, Director of Nursing and Accordius Corporate contacts. Staff who were unable to attend received the training via phone and will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11 2 liters per minute via a nasal cannula to maintain saturation levels above 92% that may be titrated every shift for shortness of breath. Resident #1 had an additional physician's order dated as initiated on 11/23/20 for vital signs to be taken every four hours for Covid-19 status. Documentation on the Medication Administration Record (MAR) revealed the oxygen saturation levels of Resident #1 were 99% at 8:00 AM and 12:00 PM on 11/27/20. There were no abnormal vital signs documented on the MAR on 11/27/20. Documentation on an assignment sheet completed by NA #1 stated that the vital signs of Resident #1 were normal except for a pulse of 121 beats per minute and oxygen saturation level of 66%. The time the vitals were taken was not documented on the assignment sheet. Documentation of the most recent vital signs taken in the electronic medical record were on 11/27/20 at 7:23 PM and did not include O2 saturation. An interview was conducted with PTA #1 on 12/4/20 at 9:54 AM. PTA #1 revealed she entered the room of Resident #1 on 11/27/20 and he was lying flat on the bed with an O2 cannula on. PTA stated Resident #1 was short of breath. PTA stated she raised the head of the bed of Resident #1 and called for NA #1 who was across the hall in another resident's room taking vital signs. PTA #1 stated NA#1 came immediately with a pulse oximeter. PTA #1 stated NA #1 took the vital signs of Resident #1 and she noted that the resident's oxygen saturation level was at 66%. PTA #1 stated NA #1 left the room immediately to tell the nurse. PTA #1 did not know the exact time she went into the room of Resident #1, but she	F 600	sign and receive materials prior to working. In-services for all staff including agency occurred in small groups to ensure social distancing or via phone for those not in attendance. Reference materials were included. The licensed nurses were educated to ask for assistance with assignment of acute changes as necessary. They may contact a charge nurse, Director of Nursing or Administrator The education was completed on 12/9/2020 by the DON. Each nursing station is equipped with the step process. Contact information can be found at the nursing stations within the Step Process instructions. Staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services occurred in small groups to ensure social distancing or via phone for those not in attendance. The Administrator, DON, and nurse management team-initiated re-education to all staff regarding abuse, neglect and exploitation on 12-8-20. An example was given that the failure to respond timely to a change in condition could be considered neglect. Staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services occurred in small groups to ensure social distancing or via phone for those not in attendance. Indicate how the facility plans to monitor its performance to make sure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12 knew it was after 3:00 PM. Documentation in a physical therapy note written by PTA #1 dated 11/27/20 stated, "[Patient] supine upon arrival with 2 [Liters] O2. Short shallow breaths. When asked how he was feeling, [patient] muttered, "fine." [Patient] was unable to follow any directions. Asked [nursing assistant] for a pulse oximeter. Vital signs checked. [Blood Pressure] = 122/76, [Heart Rate] 121-123, O2 51-66%. Nurse made aware. [Patient] positioned for comfort." The PTA note was electronically signed at 11:52 PM on 11/27/20. An interview was conducted with NA #1 on 12/3/20 at 2:20 PM. NA #1 revealed she went into the room of Resident #1 on 11/27/20 at 3:30 PM to take his vital signs. NA #1 noted the O2 saturation level of Resident #1 was at 66 %. NA #1 stated that a physical therapist (PTA #1) was in the room with Resident #1 and noted Resident #1 was having trouble breathing. NA #1 stated she immediately went to the nursing staff (Nurse #1 and Nurse # 4) while they were giving report and told them Resident #1 had an O2 saturation level of 66%. NA #1 stated that none of the nurses got up to check on Resident #1. NA #1 stated she continued to monitor Resident #1 and fed him the evening meal. NA #1 stated that she went on break after the service of the evening meal. NA #2 was interviewed on 12/3/20 at 2:49 PM. NA #2 stated she heard NA #1 tell two nurses about low O2 saturation rate for one of the residents. NA #2 stated the nurses sat there and did not get up. NA #2 stated after NA #1 went on break she was passing the room of Resident #1 and noticed	F 600	solutions are sustained Clinical medical record review for each previous 24-hours will be brought to the daily clinical meeting by the unit manager. Records will be reviewed by the Clinical Team to include Unit Manager, Director of Nursing, Social Services, Rehabilitation for changes in condition and initiation of medical treatment. The minutes from the meeting will be reviewed by the Director of Nurses 3 times per week for 4 weeks then weekly for 4 weeks, then monthly for 1 month. The Administrator will review and initial the daily clinical minutes weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the clinical minutes tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

his O2 cannula had fallen out of his nose. NA #2 stated she went into the room and he did not look right, so she immediately alerted his nurse (Nurse #2).

An interview was conducted with Nurse #1 on 12/3/20 at 12:41 PM. Nurse #1 revealed that she was the nurse on the Covid-19 unit on 11/27/20 scheduled to work from 7:00 AM to 7:00 PM. Nurse #1 stated that she took the vital signs of Resident #1 twice on her shift and they were normal. Nurse #1 stated that respiratory assessments were completed by the nursing staff and the vital signs were taken by the nurse aides two times a shift. Nurse #1 stated that at 3:00 PM on 11/27/20 two more agency nurses (Nurse # 2 and Nurse # 4) came to work on the Covid-19 unit. Nurse #1 stated that she stayed in the Covid-19 unit until 4:00 PM because three nurses were not needed. Nurse #1 stated toward the end of her shift in the middle of counting narcotics at the medication cart and giving report with another nurse (Nurse #4), the second shift aide (NA #1) came up and told them the O2 saturation levels were low on Resident #1. Nurse #1 stated that they were in the middle of counting narcotics and needed to complete the task. Nurse #1 said the other nurse (Nurse #4) told the second shift nurse aide (NA #1) she would go and check on the resident after the counting of medications was complete. Nurse #1 stated she did not go down to check the breathing status of Resident #1 because the other nurse (Nurse #4) stated she was going to check on him after the completion of counting the medications.

Nurse #2 was interviewed on 12/3/20 at 1:14 PM, 12/3/20 at 2:03 PM, and on 2/4/20 at 10:06 AM. Nurse #2 revealed she arrived to work in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

Covid-19 unit on 11/27/20 at approximately 3:30 PM. Nurse #2 said 11/27/20 was her first time in the facility. Nurse #2 stated that the Covid-19 unit already had two other nurses when she arrived (Nurse #1 and Nurse #4). Nurse #2 stated that the scheduler was called to determine if the three nurses (Nurse #1, Nurse #2 and Nurse #4) were needed. Nurse #2 stated that she received report about the residents from Nurse #1, but she was not told of any concerns with any of the residents during report. Nurse #1 stated she was never told all the residents were fine and she never told Resident #1 was having any kind of respiratory distress or any concerns at all. Nurse #2 stated she was not given any other information upon arrival to the facility. Nurse #2 stated she had 12 residents on her assignment and Nurse #4 had 12 residents on her assignment. Nurse #2 stated she did go into the electronic medical record to look at the vital signs of her 12 residents on her assignment and to familiarize herself with each of their care needs. Nurse #2 stated that after dinner one of the nurse aides (NA #2) came to her and told her Resident #1 wasn't looking right at approximately 6:45 PM. Nurse #2 stated she immediately went into the room of Resident #1 and asked him if he was okay without a response. Nurse #2 stated she found him to be cold to the touch and without a pulse. Nurse #2 stated she along with Nurse #4 moved Resident #1 to the floor using a sheet. Nurse #2 stated she started chest compressions while Nurse #4 went to look for the code status, called 911 and went to get an ambu bag to provide air to Resident #1 because mouth to mouth resuscitation could not be done on a Covid-19 resident. Nurse #2 stated that emergency medical services (EMS) arrived at approximately 7:30 PM. Nurse #2 stated that she did not see Resident #1 prior to him coding nor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

did she have knowledge of the O2 saturation level of 66% taken by NA #1. Nurse #2 stated that if she had received nursing report of any of the residents having a concern, she would have addressed it.

Nurse #4 was interviewed on 12/4/20 at 1:49 PM. Nurse #4 revealed she was an agency nurse and she arrived on the Covid-19 unit at 3:00 PM. Nurse #4 stated that Nurse #1 was sitting at a desk on the Covid-19 unit when Nurse #4 overheard NA #1 tell Nurse #1 that one of the one of the residents had low oxygen saturation levels and expressed her concern. Nurse #4 stated she had not yet received report and she did not know the name of the resident. Nurse #4 stated she expected Nurse #1 to go and check on the resident prior to leaving the facility because it was her responsibility. Nurse #4 stated Nurse #1 did not get up to check on the Resident with NA #1. Nurse #4 stated Nurse #1 went home after giving report because the Covid-19 unit did not need three nurses. Nurse #4 stated the 24 residents on the Covid-19 unit were divided between herself and Nurse #2. Nurse #4 stated that Resident #1 was not assigned to her. Nurse #4 confirmed that after dinner she was called into the room of Resident #1 by Nurse #2 upon the discovery Resident #1 was unresponsive. Nurse #4 stated that both she and Nurse #2 assisted Resident #1 to the floor. Nurse #4 stated she ran to check the code status of Resident #1, but she could not find it in the electronic medical record. Nurse #4 stated she went to get the emergency cart and found an ambu bag. Nurse #4 stated that both she and Nurse #2 continued with CPR until the paramedics arrived. Nurse #4 stated she did not realize until after the coding event that the resident with low oxygen saturation levels

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

reported by NA #1 was the same resident who coded.

Documentation on the meal service delivery schedule revealed the dinner meal service to the Covid-19 unit was served at 5:15 PM.

Documentation on percentage of meal consumption records for Resident #1 dated 11/27/20 revealed he refused breakfast and lunch and ate 0 to 25 % of the dinner meal.

NA #1 was interviewed again on 12/4/20 at 10:50 AM. NA #1 stated she left for her break on 11/27/20 at 6:45 PM and returned from break at approximately 7:20 PM.

Documentation on an EMS incident report for Resident #1 dated 11/27/20 revealed, "Station 19 was dispatched to a call for CPR in progress. Units 1910, 1911, and 1900 responded. Upon arrival on scene pt (patient) was found laying supine on the floor. Staff stated the last time seen normal was around the time [6:00 PM] and pt was found at the time 6:45 PM. Pt was cold to the touch. Nursing home staff had already initiated CPR before EMS arrival. [Automated External Defibrillator] pads were attached to the pt by EMS. Pt was asystole. (Asystole is a dire form of cardiac arrest in which the heart stops beating and there is no electrical activity in the heart.) Time of death was called in the field at the time of [7:42 PM.] Pt physician was contacted to sign Death Certificate. Pt was turned back over to nursing home staff. Proper signatures were obtained. EMS cleared." EMS was called at 7:19 PM and EMS arrived at 7:35 PM.

An interview was conducted on 12/3/20 at 4:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

PM with the lead emergency medical technician (EMT) who responded to the 911 call from the facility on 11/27/20 for Resident #1. The lead EMT stated she arrived at the facility and took over CPR from a first responder who arrived on site prior to the arrival of the EMT. The lead EMT stated three rounds of CPR were performed on Resident #1 and the resident remained in asystole.

An interview with the Director of Nursing (DON) conducted on 12/3/20 at 3:59 PM. The DON revealed on 12/2/20, NA #1 came to him in the evening and told him of her concern for the lack of response when she told the nursing staff about the low oxygen saturation levels for Resident #1 on 11/27/20. The DON stated that at that point he had not yet investigated the concern of NA #1.

An additional interview was conducted with the DON and the Administrator on 12/7/20 at 12:31 PM. The DON stated that he did not have the expectation that the nurses round on their residents at the start of the shift. The DON stated that he would have expected Nurse #4 to go and assess Resident #1 based on what information NA #1 shared with the nursing staff. The DON stated that the agency staff were shown to their work station upon arrival, given an assignment, and provided with access to the electronic medical record. The DON stated that the electronic medical record system the facility uses was known through the industry and the nurses are expected to have the knowledge of how to use it.

An interview was conducted with the physician (MD #1) of Resident #1 on 12/7/20 at 12:22 PM. MD #1 stated that he did not think the pulse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

oximetry device was used correctly on Resident #1 to obtain the measurement of 66 %. MD #1 stated that the pulse oximetry needed to be taken again correctly. MD #1 stated that Resident #1 had multiple comorbidities. MD #1 stated that if Resident #1 was in distress then an assessment should have been done while looking at the resident. MD #1 stated that he would have expected the nurse to call him if the second pulse oximetry reading correctly done gave the same low reading. MD #1 stated he doubted Resident #1 was in distress but if he was then he would have instructed the nurses to increase the oxygen he was receiving to see if that would help. MD #1 stated there were so many levels to an emergency but, if the resident was short of breath, then it could have been a medical emergency.

An interview was conducted with the facility medical director (MD #2) on 12/7/20 at 5:15 PM. MD #2 stated that the nurses should respond immediately to a report of oxygen saturation level of 66% for a resident with Covid-19 having trouble breathing. MD #2 stated the nurse should first recheck the oxygen saturation level for the resident and make sure the resident was not in distress. MD #2 stated that if the resident was in distress then the nurse should send the resident to the hospital immediately. MD #2 stated that if the pulse oximetry reading was a false reading or due to poor circulation then emergency measures are not needed. MD #2 stated that if the oxygen saturation level for a Covid-19 resident was below 90 % the nurse should send the resident to the emergency room immediately. MD #2 stated that as the medical director for the facility, the staff could call him at any time to seek his medical advice. MD #2 stated that a physician should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

informed if the resident was having respiratory distress. MD #2 stated that a confirmed pulse oximetry reading of 66 % was a medical emergency.

Documentation on the death certificate of Resident #1 revealed the immediate cause of death was congestive heart failure with the underlying causes being Hypertension, Covid-19, and Diabetes Mellitus.

The facility Administrator was notified of the immediate jeopardy on 12/5/20 at 1:30 PM.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to recheck the oxygen saturation levels, assess resident #1, continuously monitor resident #1, and initiate nursing and medical treatment for resident #1 with an acute change in condition. All residents have the potential to be affected by this deficient practice.

On 12-4-20 a record review of any vital signs available was completed by the MDS nurse on all residents in the building for the previous 72 hours. Vital signs were within baseline. No areas of concerns were identified.

Root cause analysis conducted revealed the alleged non-compliance resulted from failure to respond to an acute change in condition which was communicated as having an oxygen saturation of 66%.

A 24-hour initial allegation of neglect was faxed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

NC Department of Health Human Services, Division of Health Service Regulation on 12/8/2020 at 8:00PM.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

On 12/9/20 all residents (census 102) received a respiratory assessment to ensure there are no acute change in condition by the Director of Nursing, Unit Manager and Charge Nurse. There were no acute changes in conditions identified.

On 12/9/20 All nursing staff to include agency were in-serviced regarding the initiation of nursing and medical treatment with acute changes to include but not limited to change in vital signs, level of conscientious, etc. by either the Administrator or Director of Nursing. This will ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is change requiring notification. Discussion topics included accuracy of vital signs; acute changes from baseline; carefully listening to the patient and asking for assistance if indicated; how to get in touch with another nurse or administrative staff outside of business hours. Each nursing station is equipped with a "step process", a system which provides guidelines for what to do in the event of but not limited to falls with significant injury, equipment malfunction, elopement etc. which are guidelines on how to handle incidents and provides contact information and contact information for the Administrator, Director of Nursing and Accordius Corporate contacts. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services for all staff including agency occurred in small groups to ensure social distancing or via phone for those not in attendance. Reference materials were included.

The licensed nurses were educated to ask for assistance with assignment of acute changes as necessary. They may contact a charge nurse, Director of Nursing or Administrator The education was completed on 12/9/2020 by the DON. Each nursing station is equipped with the step process. Contact information can be found at the nursing stations within the Step Process instructions. Staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services occurred in small groups to ensure social distancing or via phone for those not in attendance.

The Administrator, DON, and nurse management team-initiated re-education to all staff regarding abuse, neglect and exploitation on 12-8-20. An example was given that the failure to respond timely to a change in condition could be considered neglect. Staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services occurred in small groups to ensure social distancing or via phone for those not in attendance.
Completed on 12/9/20/2020.

On 12-8-20 an audit was completed for code status was completed. The audit was completed to ensure every resident has a code status located on PCC (Point Click Care system for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22	F 600		

documentation) in the upper left side that is readily available to licensed nursing staff. An in-service was provided by the Administrator and Director of Nurses to all licensed nurses to include agency on how to access code status. Staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services occurred in small groups to ensure social distancing or via phone for those not in attendance.

Acute changes include but not limited to changes in vital signs, low oxygen saturation rates and breathing problems new or worsening skin issues, changes in weight, etc. will be monitored during the daily clinical review by the nursing leadership.

Nurses #1, #2, #4 no longer work at this facility. Nurses #1, #2 and #4 will not respond to nursing leadership at this facility.

On 12-9-20 an in-service was provided to all licensed nurses and Certified Nursing Assistants by the Director of Nursing regarding who is responsible to obtain an oxygen saturation. CNAs will not be obtaining oxygen saturation. Licensed staff will obtain oxygen saturation levels. Staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services occurred in small groups to ensure social distancing or via phone for those not in attendance. A written agenda was provided to staff for reference.

Date of immediate jeopardy removal 12-9-20

The credible allegation was verified on 12/10/20 at 11:00 AM as evidenced by observations, staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23 interviews, and record review. Interviews were conducted with the nursing staff to confirm in-services on the initiation of nursing and medical treatment with acute changes to include the step process were completed. Interviews were conducted with the licensed staff to confirm in-services on asking for assistance with assignment of acute changes were completed. Interviews were conducted with both front line and administrative staff to confirm all staff had been re-educated on the facility abuse, neglect, and exploitation policy. Observations and interviews were made of the availability of the step process and administrative contact information at the nursing stations. Documentation of audits of vitals, code status audits, a 24-hour report of neglect for Resident #1, daily clinical risk meeting forms, and in-service education was reviewed. The facility removed immediate jeopardy on 12/9/20.	F 600		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and physician interview, the facility failed to operationalize effective systems so staff could respond to emergency situations as needed for 3 of 3 residents (Resident # 6, # 1, # 9).	F 678	Address how corrective action will be accomplished for those residents found to be have been affected by the deficient practice. Resident #6 and #1 expired. Resident #9	1/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 24 Resident # 6 and # 1 expired in the facility. Resident # 9 was in acute distress. Immediate Jeopardy began on 11/17/20 when Resident #6 was found without a pulse and cold and Nurse #3 was unable to find the resident's code status and was unable to obtain help from other nursing staff to locate the code status or assist in CPR prior to the arrival of Emergency Medical Services (EMS). Immediate Jeopardy began on 11/27/20 when Resident #1 was found unresponsive and Nurse #2 and Nurse #4 were unable to find the resident's code status. On 11/27/20 there were 24 residents on the Covid-19 unit. Also, on 12/03/20, Nurse #4 was unable to find an ambu bag on the emergency cart when Resident #9 was experiencing agonal breathing and may have required CPR prior to the arrival of EMS. The immediate jeopardy was removed on 12/9/20 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included: The facility policy for Cardiopulmonary Resuscitation (CPR) stated, "The facility will provide basic life support, including CPR -Cardiopulmonary Resuscitation, when a resident requires emergency respiratory support care, prior to the arrival of emergency medical services, and consistent with the resident Advance Directives, and physician orders." The facility policy in part required a staff member to verify the	F 678	discharged to the hospital. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 12/9/20 All nursing staff to include agency were in-serviced regarding the initiation of nursing and medical treatment with acute changes to include how and when to perform CPR but not limited to change in vital signs, level of conscientious, etc. by either the Administrator or Director of Nursing. This will ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is change requiring notification. Discussion topics included accuracy of vital signs; acute changes from baseline; carefully listening to the patient and asking for assistance if indicated; how to get in touch with another nurse or administrative staff outside of business hours. For example, if assistance is needed for the main building in the event of an emergency you may ask for help and notify administration for coverage. Each nursing station is equipped with a "step process", a system which provides guidelines for what to do in the event of CPR performed or not initiated per resident's advanced directive which are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 25 DNR (Do Not Resuscitate) or code status of the individual prior to starting CPR. The facility policy listed an ambu bag as a needed supply on the crash cart. In the procedure for CPR, the policy indicated both chest compressions and breaths via a resuscitator or an ambu bag were required. The standard of practice for death and resuscitation dated as revised 5/2017 was used as policy for the facility. The standard of practice stated in part that it was the responsibility of the Director of Nursing to identify, develop, and update policies, standards, and procedures related to nursing care. The same standard of practice stated emergency policies should address witnessed and unwitnessed cardiopulmonary arrests, presence or absence of DNR orders, anticipated/expected deaths, assessment guidelines, and documentation requirements. 1. Resident #6 was admitted to the facility from another facility on 11/13/20 with a primary diagnosis of Covid-19. Resident #6 had additional cumulative diagnoses some of which included Hypertension, Diabetes Mellitus, and Dementia. Resident #6 had a 5- day Medicare Minimum Data Set assessment dated 11/17/20 which revealed he was cognitively impaired and required extensive to total assistance with activities of daily living. Resident #6 was coded as receiving oxygen while he was at the facility. The code status of Resident #6 was located under the "Miscellaneous" tab in the electronic medical record on the 12th page of the admission documentation. Resident #6 was a full code.	F 678	guidelines on how to handle incidents and provides contact information and contact information for the Administrator, Director of Nursing and Accordius Corporate contacts. The Director of nursing will ensure staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services provided by the Director of Nursing or the Administrator were completed for all staff including agency occurred in small groups to ensure social distancing or via phone for those not in attendance. The licensed nurses were educated by the Director of nursing or the administrator to ask for assistance with any assignments and on to for assistance with acute changes in residents as needed. They may contact a charge nurse, Director of Nursing or Administrator their contact numbers and extensions can be found at the nurses' stations. The education was completed on 12/9/2020 by the DON. Each nursing station is equipped with the step process. The Director of nursing will ensure staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services provided by the Director of Nursing or the Administrator were completed for all staff including agency occurred in small groups to ensure social distancing or via phone for those not in attendance. On 12-8-20 an audit was completed by the Social Services Director for code	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 26 An interview with Nurse #3 revealed on 11/16/20 she worked a double shift in the Covid-19 unit from 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM ending on 11/17/20. Nurse #3 confirmed she was a travel nurse employed by an agency. Nurse #3 stated Resident #6 was found in his bed cold and without a pulse just prior to the end of her shift on 11/17/20 at approximately 6:00 AM. Nurse #3 stated she looked in the electronic record system in the physician orders and on the face sheet for the resident's code status while she simultaneously called 911. Nurse #3 stated she knew she needed to find the code status. Nurse #3 stated she needed to get the resident help immediately if he was to be resuscitated. Nurse #3 stated she felt she was put in a difficult position because if the resident was a full code then she needed to start CPR and if he was a DNR (Do Not Resuscitate), she was not supposed to start CPR. Nurse #3 stated she could not find the code status and she was unable to initiate CPR by herself on a Covid-19 resident, so she called Code Blue over the intercom. Code Blue indicates a medical emergency. Nurse #3 explained that one nurse was needed to do compressions while another nurse was needed to use the ambu bag over the mouth because mouth to mouth resuscitation could not be done on a Covid-19 positive resident. Nurse #3 stated that the phone numbers for the Administrator and the Director of Nursing were not posted anywhere. Nurse #3 stated she requested the phone numbers of the facility Administrator and the Director of Nursing from the other unit nurse on the phone. Nurse #3 stated that the other unit nurse told her she did not have their phone numbers. Nurse #3 stated she called the facility scheduler to ask for the phone number of the facility Administrator, so she	F 678	status validation in the medical record. The audit was completed to ensure every resident has a code status located on PCC (Point Click Care system for documentation) in the upper left side that is readily available to licensed nursing staff. This audit included the "blue book" located at each nursing station. This book includes the face sheet and code status for each resident in the event of a power outage. An in-service was provided by the Administrator and Director of Nurses to all licensed nurses to include agency on how to access code status. The Director of nursing will ensure staff who were unable to attend received the training via phone and will sign and receive materials prior to working. In- services provided by the Director of Nursing or the Administrator were completed for all staff including agency occurred in small groups to ensure social distancing or via phone for those not in attendance. The Director of Nursing will be responsible for making sure the code status is in place at all times and the information is readily at hand for licensed nurses On 12-8-20 the Director or Nurses audited all crash carts in the building to ensure all carts are equipped with the necessary equipment to complete CPR (Cardiopulmonary Resuscitation). Crash Carts are sealed with a tag with a number. Only when the tag is broken an audit is required to ensure all equipment is available for immediate use. Replacement supplies are available for immediate use and stored in the supply room. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 27 get assistance finding the code status of Resident #6. Nurse #3 stated that Emergency Medical Services (EMS) arrived at approximately 6:15 PM, and they were unable to revive the resident. Nurse #3 stated ultimately EMS called somebody to get the code status of the resident. Nurse #3 stated she was never able to find Resident #6's code status. Nurse #3 stated that she was never told where to find the resident's code status at the facility, but she thought the code status should have been in the physician orders or on the face sheet in the electronic medical record. Nurse #3 confirmed she did not perform CPR on Resident #6 prior to the arrival of EMS. Nurse #3 stated that the next day, 11/18/20, she went to the Director of Nursing to express her concern of her inability to find the code status of Resident #6. The facility scheduler was interviewed on 12/4/20 at 3:10 PM. The facility scheduler stated that she received a phone call from Nurse #3 on 11/17/20 requesting the phone number of the Administrator. The facility scheduler stated she called the Administrator to tell her that someone had passed, and the nurse was unable to find the code status. Documentation in the nursing notes on 11/17/20 at 6:57 AM, written by Nurse #3 stated, "Resident was found not breathing. Writer contacted staff for assistance. [Administrator] notified. [Medical Doctor] notified. Son [name] notified. Son stated he will contact the building [with] regards to where the body will be sent." Documentation in an emergency medical services report for Resident #6 on 11/17/20 revealed, "HCEMS (Hertford County Emergency Medical Services) dispatched to priority one call	F 678	Director of Nursing assigned the task of checking the crash cart to the Unit Manager or Designee. An audit is performed by the charge nurse on duty when the tag is broken, and supplies are replenished as necessary. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained A Crash Cart Audit Monitoring Tool will be completed by the Unit Manager or Supervisor on Duty daily. The Crash Cart Audit Monitoring Tool will be reviewed by the Director of Nurses 3 times per week for 4 weeks then weekly for 4 weeks, then monthly for 1 month. The Administrator will review and initial the Crash Cart Monitoring Tool weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified area of concern. The Executive Quality Improvement Committee will meet monthly and review the crash cart monitoring tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months. A Code Status Audit will be completed by Social Services 3 times per week for 4 weeks then weekly for 4 weeks, then monthly for 1 month. The Director of Nurses will review and initial the audit weekly for 12 weeks for completion and will complete retraining with the appropriate team member for ay identified area of concern. The Executive Quality Improvement Committee will meet	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 28 for a cardiac arrest at Creekside ...Dispatch advised crew to enter through the Covid hall door .... On scene, crew entered facility and was directed to PT (patient). NH (nursing home) advised multiple times that the PT was a DNR. NH staff was instructed to get the PT's DNR (Do Not Resuscitate) paperwork for EMS to visualize ... PT paperwork was obtained from PT nurse. She advised the PT had only been at the facility for 2 days and that they did not have all the PT's paperwork. PT history other than Covid-19 was unknown ..." An interview was conducted with the Director of Nursing (DON) on 12/3/20 at 3:59 PM. The DON stated that the first thing he expected the nursing staff to do when a resident was unresponsive was to check the code status of the resident. The DON indicated the code status was in a book at the nurses' station and in the electronic medical record. An interview was conducted with the DON and the Administrator on 12/7/20 at 12:31 PM. The DON stated upon arrival to begin to work at the facility the agency nursing staff were shown to their work station, given an assignment, and provided with access to the electronic medical record. The DON stated the electronic medical record system the facility uses was known through the industry and the nurses were expected to have the knowledge of how to use it. The DON stated he did at one point realize not all the residents had a code status in the electronic medical record. The DON stated he went through and made sure all residents had a code status located on the gray bar on the electronic medical record visible on every screen on a resident's chart. The DON stated it would be an ongoing	F 678	monthly and review the Code Status Audit and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 29	F 678		

process for him to go through and check to make sure the code status was in the electronic medical record of each resident. Both the Administrator and the DON agreed CPR could be performed by one nurse on a resident until EMS arrived; nurses working on other halls do not need to go to the Covid-19 unit to help.

An interview was conducted with the facility Medical Director on 12/7/20 at 5:15 PM. The Medical Director stated that there was an expectation that the nursing staff be able to quickly find the code status of a resident. The Medical Director stated that if a resident started to code, the nurse should first check the code status while someone calls 911. The Medical Director stated that one nurse on the Covid-19 unit could not do CPR alone and help needed to be called from the other halls in the facility.

2. Resident #1 was admitted to the facility from another facility on 11/21/20 with cumulative diagnoses some of which included Covid-19, Type 2 Diabetes Mellitus, Hypertension, Dementia, and Dysphagia.

The location of the code status of Resident #1 was in the care plan dated 11/23/20. Resident #1 had a focus area for the advance directive of full code.

Documentation in a nursing progress note for Resident #1 dated 11/27/20, written by Nurse #2, stated, "Patient was alert and responsive during the beginning of the shift. Patient ate about 25% of dinner. After dinner while CNA's were picking up trays at approximately 6:45 PM patient was found unresponsive. Compressions were immediately started; ambulance crew were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 30	F 678		

called. When ambulance arrived, they took over with compressions. Pulse could not be reestablished. Patient was then pronounced expired by emergency crew. Proper staff were notified (DON, Social Worker)."

Nurse #2, a travel nurse employed by an agency, was interviewed on 12/3/20 at 1:14 PM, 12/3/20 at 2:03 PM and on 12/4/20 at 10:06 AM. Nurse #2 revealed she arrived to work in the Covid-19 unit on 11/27/20 at approximately 3:30 PM. Nurse #2 said 11/27/20 was her first time in the facility and she was not given any directions or orientation to the unit upon arrival. Nurse #2 stated that she received report about the residents from Nurse #1, but she was not told of any concerns with any of the residents during report. Nurse #1 stated she was never told all the residents were fine and she never told Resident #1 was having any kind of respiratory distress or any concerns at all. Nurse #2 stated she was not given any other information upon arrival to the facility. Nurse #2 stated she had 12 residents on her assignment and Nurse #4 had 12 residents on her assignment. Nurse #2 stated she did go into the electronic medical record to look at the vital signs of her 12 residents on her assignment and to familiarize herself with each of their care needs. Nurse #2 stated that after dinner one of the nurse aides (NA #2) came to her and told her Resident #1 wasn't looking right at approximately 6:45 PM. Nurse #2 stated she immediately went into the room of Resident #1 and asked him if he was okay without a response. Nurse #2 stated she found him to be cold to the touch and without a pulse. Nurse #2 stated she along with Nurse #4 moved Resident #1 to the floor using a sheet. Nurse #2 stated she started chest compressions while Nurse #4 went to look for the code status,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 31	F 678		

called 911 and went to get an ambu bag to provide air to Resident #1 because mouth to mouth resuscitation could not be done on a Covid-19 resident. Nurse #2 indicated that when Nurse #4 was unable to find the code status of Resident #1, she went looking for the code status of the resident after EMS arrived to assist with CPR. Nurse #2 stated she was unable for an hour and a half to get in contact with the Director of Nursing to receive assistance in locating the code status of Resident #1.

Nurse #4, a travel nurse employed by an agency, was interviewed on 12/4/20 at 1:49 PM. Nurse #4 stated at the start of the shift on 11/27/20 Nurse #2 did not have access to the electronic medical records, but that issue was resolved shortly after starting her shift. Nurse #4 stated that she remembered Nurse #2 stating to her there was no way to check the code status of the residents. Nurse #4 stated Nurse #2 was complaining there was no book or folder with the code status of the resident's in it, no list of physician phone numbers, and no list of phone numbers for the Administrator or Director of Nursing on the Covid-19 unit. Nurse #4 stated that all the needed information should have been given to them at the start of the shift and it was not. Nurse #4 indicated she was not given any orientation to the Covid-19 unit at the start of her shift. Nurse #4 stated after the paramedics took over CPR on Resident #1, she ran to the front of the building to get the attention of Nurse #3 on the other unit. Nurse #3 answered the door and told Nurse #4 she would assist her in trying to contact someone to get the code status of Resident #1. Nurse #4 stated one of the nurse aides suggested she call the facility the resident arrived from to obtain the code status. Nurse #4 stated she was not aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 32	F 678		

of the other facility or who to call.

An interview with the Director of Nursing (DON) on 12/3/20 at 3:59 PM. The DON stated that the first thing he expected the nursing staff to do when a resident was unresponsive was to check the code status of the resident. The DON indicated the code status was in a book at the nurses' station and in the electronic medical record. The DON confirmed Resident #1 was a full code and the Nurses were correct in starting CPR prior to the arrival of EMS.

An interview was conducted with the DON on 12/7/20 at 12:31 PM. The DON stated that the agency staff were shown to their work station upon arrival, given an assignment, and provided with access to the electronic medical record. The DON stated the electronic medical record system the facility uses was known through the industry and the nurses were expected to have the knowledge of how to use it. The DON stated he did at one point realize not all the residents had a code status in the electronic medical record. The DON stated he went through and made sure all residents had a code status located on the gray bar on the electronic medical record visible on every screen on a resident's chart. The DON stated it would be an ongoing process for him to go through and check to make sure the code status was in the electronic medical record of each resident. The DON confirmed Resident #1 was a full code and CPR needed to be initiated when the resident was found unresponsive on 11/27/20.

An interview was conducted with the facility Medical Director on 12/7/20 at 5:15 PM. The Medical Director stated that there was an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 33	F 678		

expectation that the nursing staff be able to quickly find the code status of a resident. The Medical Director stated that if a resident started to code, the nurse should first check the code status while someone calls 911.

3. The most recent annual Minimum Data Set assessment, completed on 10/7/20 at a previous facility, coded Resident #9 as alert and oriented. Resident #9 required limited to extensive assistance with activities of daily living except for eating.

Resident #9 was admitted to the facility from another facility on 11/22/20 with diagnoses of Covid-19, Heart failure, Hypertension, Diabetes Mellitus, Depression, and Dementia.

Documentation in a nursing progress note dated 12/3/20 at 3:10 PM revealed Resident #9 was experiencing agonal breathing (gasping when a person is struggling to breathe), had a peripheral capillary oxygen saturation rate of 84 % with room air. Resident #9 was seen for a virtual visit from a physician and an order was given to send her to the emergency room.

Documentation in a nursing progress note dated 12/3/20 at 3:45 PM revealed Resident #9 was sent to the emergency room alert and responsive but remained hypoxic (inadequate oxygen level) and tachycardic (rapid heartbeat). Resident #9 was placed on a nonrebreather by EMS.

Documentation in an emergency medical services report for Resident #9 on 12/3/20 revealed EMS was called to the Covid-19 unit at 3:18 PM. Upon arrival the EMS staff noted Resident #9 had cold extremities and oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 34	F 678		

saturation levels could not be obtained. After registering a pulse, the resident was put on a nonrebreather. EMS noted the resident was transferred to a stretcher and put in the ambulance for transport to the hospital.

Nurse #4, a travel nurse employed by an agency, was interviewed on 12/4/20 at 1:49 PM. Nurse #4 stated Resident #9 was slumped over and having trouble breathing on 12/3/20 when she was working on the Covid-19 unit of the facility on the 3:00 PM to 11:00 PM shift. Nurse #4 stated an ambu bag was not on the emergency cart. Nurse #4 stated the emergency cart had not been restocked on the Covid-19 unit in preparation for her shift. Nurse #4 stated she called EMS for Resident #9, told the 911 operator the Covid-19 unit did not have the supplies for CPR, and the ambulance needed to come quickly in case the resident was to code. Nurse #4 stated she did not know how she was going to do CPR on a resident in the Covid-19 unit if she had needed the supplies to do so and did not have them. Nurse #4 stated that most of the Residents on the Covid-19 unit had the advance directive of full code.

Observations and an interview with Nurse #8, a travel nurse employed by an agency, were made on the Covid-19 unit on 12/5/20 beginning at 8:37 AM. The crash cart on the unit was observed to not contain an ambu bag. Nurse #8 stated she was instructed to only do chest compressions on Covid-19 residents and that an ambu bag was not needed. Nurse #8 indicated it was the facility policy that it was the responsibility of the evening shift to restock the emergency cart with needed items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 35	F 678		

The Director of Nursing (DON) and the Administrator were interviewed on 12/7/20 at 12:31 PM. The DON stated an ambu bag should be used in place of mouth to mouth resuscitation in addition to chest compressions on the Covid-19 unit when CPR was needed. The Administrator stated that the facility policies and procedures for CPR needed to be followed.

An interview was conducted with the facility Medical Director on 12/7/20 at 5:15 PM. The Medical Director stated CPR was not to be done any differently on the Covid-19 unit, but an ambu bag was to be used along with chest compressions.

The facility Administrator was notified of the immediate jeopardy on 12/16/20 at 11:20 AM.

The facility provided an Immediate Jeopardy removal credible allegation on 12/16/20 at 4:24 PM.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to assure the facility staff were aware of how to locate the code status for Resident #6 and Resident #1. The facility failed to provide the needed supplies for CPR on the Covid-19 unit for Resident #9. The facility failed to provide orientation for agency nurses on how to perform CPR when alone on the Covid-19 unit for Resident #6.

All residents have the potential to be affected by this deficient practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 36	F 678		

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 12/9/20 All nursing staff to include agency were in-serviced regarding the initiation of nursing and medical treatment with acute changes to include how and when to perform CPR but not limited to change in vital signs, level of conscientious, etc. by either the Administrator or Director of Nursing. This will ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is change requiring notification. Discussion topics included accuracy of vital signs; acute changes from baseline; carefully listening to the patient and asking for assistance if indicated; how to get in touch with another nurse or administrative staff outside of business hours. For example, if assistance is needed for the main building in the event of an emergency you may ask for help and notify administration for coverage. Each nursing station is equipped with a "step process", a system which provides guidelines for what to do in the event of CPR performed or not initiated per resident's advanced directive which are guidelines on how to handle incidents and provides contact information and contact information for the Administrator, Director of Nursing and Accordius Corporate contacts. The Director of nursing will ensure staff and any agency or travel nurses who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services provided by the Director of Nursing or the Administrator were completed for all staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 37	F 678		

including agency and travel nurses occurred in small groups to ensure social distancing or via phone for those not in attendance.

The licensed nurses were educated by the Director of nursing or the administrator to ask for assistance with any assignments and on to for assistance with acute changes in residents as needed. They may contact a charge nurse, Director of Nursing or Administrator their contact numbers and extensions can be found at the nurses' stations. The education was completed on 12/9/2020 by the DON. Each nursing station is equipped with the step process. The Director of nursing will ensure staff including agency and travel nurses who were unable to attend received the training via phone and will sign and receive materials prior to working. In-services provided by the Director of Nursing or the Administrator were completed for all staff including agency and travel nurses occurred in small groups to ensure social distancing or via phone for those not in attendance.

On 12-8-20 an audit was completed by the Social Services Director for code status validation in the medical record. The audit was completed to ensure every resident has a code status located on PCC (Point Click Care system for documentation) in the upper left side that is readily available to licensed nursing staff. This audit included the "blue book" located at each nursing station. This book includes the face sheet and code status for each resident in the event of a power outage. An in-service was provided by the Administrator and Director of Nurses to all licensed nurses to include agency on how to access code status. The Director of nursing will ensure staff who were unable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 38	F 678		

attend including agency and travel nurses received the training via phone and will sign and receive materials prior to working. In- services provided by the Director of Nursing or the Administrator were completed for all staff including agency and travel nurses occurred in small groups to ensure social distancing or via phone for those not in attendance. The Director of Nursing will be responsible for making sure the code status is in place at all times and the information is readily at hand for licensed nurses

On 12-8-20 the Director or Nurses audited all crash carts in the building to ensure all carts are equipped with the necessary equipment to complete CPR (Cardiopulmonary Resuscitation). Crash Carts are sealed with a tag with a number. Only when the tag is broken an audit is required to ensure all equipment is available for immediate use. Replacement supplies are available for immediate use and stored in the supply room. The Director of Nursing assigned the task of checking the crash cart to the night nurse. An audit is performed by the charge nurse on duty when the tag is broken, and supplies are replenished as necessary.

Date of Immediate Jeopardy removal 12-9-20

The credible allegation was verified on 12/17/20 at 4:12 PM as evidenced by observations, staff interviews, and record review. Interviews were conducted with the nursing staff to conform in-services were done on how and when to conduct CPR, how and when to request assistance with CPR, and how to locate the code status of a resident. Observations were made of the emergency carts for each unit to visualize the carts were sealed with a tag and the supply audits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 678	Continued From page 39 were complete. Observations were made at each nursing unit to confirm emergency phone numbers and the step process was posted as well as for the availability of the blue book with the code status of each resident. Resident records were reviewed of the new admissions to assure code status was in the electronic medical record. Documentation of the code status audit, emergency cart audit, and in-service education on the STEP process and CPR was reviewed. The "STEP" process is a system which provides guidelines for what to do in the event of CPR performed or not initiated per resident's advanced directive which are guidelines on how to handle incidents and provides contact information and contact information for the Administrator, Director of Nursing and Accordius Corporate contacts. The facility's immediate jeopardy removal date of 12/9/20 was validated.	F 678		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		1/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 40 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Pharmacist interview, and Pharmacy manager interview the facility failed to safeguard the medications of deceased residents on the Covid-19 unit by keeping them locked and only accessible to appropriate personnel. Findings included: Observations were made on the Covid-19 unit of the facility on 12/5/20 at 8:51 PM. An office room on the unit was observed to contain two large boxes on the floor filled with medication punch cards. An interview was conducted with Nurse #8 on the Covid-19 unit on 12/5/20 at the same time as the observation of the medications at 8:51 PM. Nurse #8 stated that the multiple medication punch cards were on the floor because the pharmacy would not take the medications of the deceased Covid-19 residents. Nurse #8 stated that the door to the office was always left open and the door did not lock. Nurse #8 confirmed, and it was observed the narcotics of the deceased Covid-19 residents were kept locked up. An interview was conducted with the Director of	F 761	Address how corrective action will be accomplished for those residents found to be have been affected by the deficient practice. Medications of discharged residents on the Covid-19 unit have been removed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Resident specific medications are stored on the medication carts and any other medications will only be stored in designated locked medication storage rooms. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur An audit of all medication storage area to ensure it is locked and only accessible to appropriate personnel was completed on 1-7-21 by Director of Nurse. Staff was in-serviced on 1-8-21 regarding the safeguard of medications by keeping	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 41 Nursing on 12/7/20 at 12:31 PM. The Director of Nursing stated the medication punch cards that were observed on 12/5/20 on the Covid-19 unit had been returned to the pharmacy. The Director of Nursing stated it was a best practice to keep medication punch cards to be kept in a locked location. An interview was conducted with the facility consultant pharmacist on 12/7/20 at 11:15 AM. The consultant pharmacist stated that usually a driver from the pharmacy comes to pick up the medications of the deceased residents. The consultant pharmacist stated she was not familiar with what the facility should do with the medications of the deceased residents on the Covid-19 unit but acknowledged the medications should be kept in a locked location. An interview was conducted with the pharmacy manager of the pharmacy the facility on 12/8/20 at 12:45 PM. The pharmacy manager stated that about 6 months ago, at the beginning of the Covid-19 pandemic, the pharmacy was restricting return pick ups of medications to once a week. The pharmacy manager stated that currently the pharmacy will pick up medications every single day after the appropriate paperwork was filled out. The pharmacy manager stated the pharmacy never stopped taking returns of medications. The pharmacy manager stated that while awaiting pick up from the pharmacy the medications should be kept locked up until the pick-up time.	F 761	them locked and only accessible to appropriate personnel and how to appropriately and efficiently send unused medications back to pharmacy after a resident has discharged. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained A Medication Storage Monitoring Tool will be completed by the Unit Manager or Supervisor on Duty. The Medication Storage Monitoring Tool will be reviewed by the Director of Nurses 3 times per week for 4 weeks then weekly for 4 weeks, then monthly for 1 month. The Administrator will review and initial the Medication Storage Monitoring Tool weekly for 12 weeks for completion and will compete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the Medication Storage Monitoring Tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		1/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility 1. failed to put Covid-19 positive residents in separate rooms when separate rooms were available per Centers for Disease Control (CDC) guidelines and did not follow facility policy for cohorted Covid-19 positive residents on the Covid-19 unit for 2 (Resident #7 and Resident #8) of 2 residents reviewed for infection control on the Covid-19 unit 2. failed to perform wound care following wound care procedures for 1 (Resident #4) of 3 residents reviewed for wound care. This occurred during a Covid-19 pandemic. Findings included:	F 880	Address how corrective action will be accomplished for those residents found to be have been affected by the deficient practice. Resident #7 was discharged from this facility on 12-11-20 Resident #8 was discharged from this facility on 12-10-20. Resident #4 was assessed to ensure the resident is free of infection on 1-6-21 by the Director of Nurses. Address how the facility will identify other residents having the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44 1. Documentation on the CDC guidance entitled, "Responding to Coronavirus (Covid-19) in Nursing Homes" updated 4/30/20 stated, "Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room." The facility Covid-19 plan revised on 10/31/20 stated, "Upon notification of a + (positive) result or onset of symptoms residents who cohort will have their beds placed on opposite sides of the room (if able) at a minimum of 6 feet apart. Curtains between resident's beds remained closed." Documentation on the Covid-19 plan also stated, "Confirmed or suspected Covid-19 residents in isolation will always have their doors closed. Must care plan any exceptions." a. Resident #8 was admitted to the facility on 11/20/20 from the hospital after being sent to the hospital from another facility due to a diagnosis of Covid-19. b. Resident #7 was admitted to the facility on 11/23/20 from another facility due to a diagnosis of Covid-19. Observations were made on the Covid-19 unit on 12/5/20 at 8:39 AM. Resident # 7 was observed to be in the A bed and Resident #8 was in the B bed in Room 314. The door to the room was open with no curtain pulled between the bed. There were no staff members in the area in or near the room. An interview was conducted with Nurse #8 on 12/5/20 at 8:39 AM. Nurse #8 stated she thought the two residents came together on the same day from another facility and the residents were	F 880	affected by the same deficient practice. Residents residing on the Covid-19 Unit have the potential to be affected by this deficient practice. Residents were reviewed on 1-6-21 to ensure residents residing on the Covid-19 Unit are in private rooms when private rooms are available by the Administrator. Residents who require wound care have the potential to be affected by this deficient practice. Residents who require wound care were assessed for signs and symptoms of infection on 1-8-21 by the Director of Nurses. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Staff were educated on 1-8-21 not to move residents and to follow facility policy regarding the Covid-19 Plan regarding use of the Covid-19 Unit. Licensed Staff to include agency staff were educated on the facility wound care policy on 1-8-21 by the Director of Nurses or Designee which indicates the steps for wound care procedures. Newly hired staff will be educated on the facility wound care policy during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Census Report will be reviewed by the Admissions Coordinator 3 times per week for 4 weeks then daily for 4 weeks then monthly times one month to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 roommates at the other facility. Nurse #8 went to confirm the information she provided was accurate, but she stated she could not find anything in the resident's medical records to confirm what she said. An interview was conducted with the Administrator on 12/7/20 at 12:31 PM. The Administrator stated that per the facility infection control policy it was okay to keep residents on the Covid-19 unit in the same room as long as they were 6 feet apart, the curtain was pulled around the beds, and the door was closed to the room. An interview was conducted with the Admissions Coordinator and the Administrator on 12/10/20 at 12:31 PM. The Admissions Coordinator indicated the plan was to have Resident's #7 and #8 in individual rooms but there had been miscommunication resulting with Residents #7 and #8 cohorted in the same room. The Administrator stated that it was too hard to keep a curtain pulled between the beds and the residents were put in separate rooms. The facility Administrator and the Admissions Coordinator both confirmed there were unoccupied rooms available on the Covid-19 unit when Resident #7 arrived on 11/23/20. 2. The undated facility wound care policy indicated the steps in the wound care procedure. The first step was to use disposable cloth, such as paper towel, to establish a clean field on the resident's overbed table. The second step was to wash and dry hands thoroughly. Part of the third step was to place a disposable cloth next to the resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Step sixteen was to discard disposable items to	F 880	residents are in private rooms on the Covid-19 Unit as private rooms are available. The Administrator will review and initial the Census report weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the Census Report and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months The Director of Nurses will audit 3 dressing changes for wound care provided by licensed staff weekly times 4 weeks then 1 dressing change weekly times 4 weeks then monthly times 1 month utilizing the Wound Care Audit Monitoring Tool. The Administrator will review and initial the Wound Care Audit Monitoring Tool weekly for 12 weeks for completion and will complete retraining with the appropriate team member for any identified areas of concern. The Executive Quality Improvement Committee will meet monthly and review the Wound Care Audit Monitoring Tool and address any issues, concerns and/or trends. The team will make changes as needed to include the continued frequency of monitoring for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46	F 880		

include disposable gloves into the designated container.

Observation of wound care on the right heel and right great toe of Resident #4 was conducted on 12/3/20 at 10:25 AM. Nurse Aide (NA #6) used sanitizer on her hands explaining that she would usually wash her hands, but maintenance was fixing the bathroom She then prepared the supplies needed for the dressing change at the treatment car placing them on the paper towels. Nurse Practitioner (NP #1) was also present to provide wound care. NP #1 was observed using sanitizer on her hands before entering Resident #4's room. NA #6 placed the paper towels with the dressing supplies on the bedding. NP #1 lifted Resident #4's right leg, removed the wrapping and bandage from the right heel and place the soiled bandages on the bedding. NP #1 then placed Resident #4's heel directly on the bedding. NA #6 then lifted the heel revealing a bloody spot on the bed sheet. After cleaning the right heel and right great toe with saline and gauze pads, NA #6 placed the soiled gauze pads on the bedding. NA #6 then gathered the dirty dressing materials from the bedding, exited the room and placed them in the waste bin on the treatment cart.

NA #6 was interviewed directly after the observation on 12/3/20 at approximately 10:40 AM. NA #6 acknowledged there had been a garbage can available for use and within reach in Resident #4's room. NA #6 stated that she usually put the dirty dressings into the garbage can or a garbage bag but acknowledged she did not do that this time and instead took the soiled dressing out of the room before disposing of them in the treatment cart waste bin. She also stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 12/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 usually used the bedside table to place the dressing supplies whole providing wound care. She explained she had not placed the supplies on the bedside table because Resident #4's breakfast tray had been on the table. An interview with the Director of Nursing was conducted on 12/3/20 at 1:52 PM. The Director of Nursing stated that the best practice was to use a trash bag to deposit dirty dressings and not the bedding of the resident unless the linens were going to be changed out.	F 880		