PRINTED: 03/24/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE :	
		345128	B. WING		0	
NAME OF D	DOVIDED OD SUDDI IED	343120	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	02/2	23/2022
NAME OF PI	ROVIDER OR SUPPLIER					
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX			(X5) COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
F 000	INITIAL COMMENTS	;	F 0	00		
	An unannounced cor	mplaint investigation was				
		2/22 through 02/04/22 with				
		obtained through 02/23/22 te was changed to 02/23/22.				
		tions investigated and 32 of				
	the allegations were s	substantiated with citation				
	and 2 of the 39 were citation. See Event ID					
	Immediate Jeopardy	was identified at:				
	CFR 483.10 at citatio	n F-580 at a scope and				
	l •	ate Jeopardy began on				
	12/17/21 and was ren	noved on 02/08/22. n F-686 at a scope and				
		ate Jeopardy began on				
	01/27/22 and was ren	moved on 02/08/22.				
		n F-757 at a scope and				
	severity of K. immedia	ate Jeopardy began on				
		n F-835 at a scope and				
		ate Jeopardy began on				
	12/17/21 and was ren	moved on 02/08/22.				
	Citations F-550, F-67	7, F-686 and F-757				
	constituted Substand	ard Quality of Care.				
		was conducted on 02/11/22.				
F 550			F 5	50		3/25/22
SS=H	CFR(s): 483.10(a)(1)	(2)(b)(1)(2)				
	§483.10(a) Resident l	Rights.				
	The resident has a rig	ght to a dignified existence,				
		nd communication with and				
	access to persons an	ld services inside and cluding those specified in				
	this section.	oluding those specified in				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	1	(X6) DATE

Electronically Signed 03/09/2022

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

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	· · · · · ·	0212312022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 550	with respect and digresident in a manner promotes maintenancher quality of life, recindividuality. The facingromote the rights of \$483.10(a)(2) The faces to quality careseverity of condition, must establish and material provision of services residents regardless. \$483.10(b) Exercise The resident has the rights as a resident or resident of the Unit \$483.10(b)(1) The faces resident can exercise interference, coercion from the facility.	ty must treat each resident nity and care for each and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and the resident. cility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen	F 5	<u> </u>			
	reprisal from the facilinghts and to be supplexercise of his or her subpart. This REQUIREMEN by: Based on observation phone video footage, the facility failed to the	ity in exercising his or her ported by the facility in the rights as required under this I is not met as evidenced ons, record review, cell resident and staff interview eat a resident in a dignified facility in a resident spoke rudely to		The statements included are n admission and do not constitute agreement with the alleged def herein. The plan of correction	e ïciencies		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			С	
NAME OF D	DOVIDED OD CUIDDUED	343120	B. WING_	CTDEET ADDRESS CITY STATE	710 0005	02/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET			
				STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 550	Continued From page	e 2	F 5	50			
	(Resident #4), failed to dignified manner by m	not providing incontinence and double and triple (Resident 3, Resident #5, at #10, and Resident #11) for wed. The residents stated inence care and wearing them feel bad, low and like aning, embarrassed and		completed in the completed regulations as in compliance with all regulations the center take the actions set for plan of correction. The correction constitutes allegation of compliant deficiencies cited have completed by the date. How corrective action accomplished for thos have been affected by practice; The facility failed to tredignified manner when	outlined. To remain federal and state has taken or will orth in the following he following plan of the centers had alleged he been or will be he indicated. will be he residents found to you the deficient had state had been to be a resident found to you the deficient had state had been and the following the f		
	(MDS) dated 10/28/2 was cognitively intact activities of daily living Resident #4 was interested to the facility since Octoon the facility were the wastaff were rude and years and had very were exacerbated who medication. He explain very strict schedule for him to have the best of at the facility he could because the medication.	1 revealed that Resident #4 2 and was independent with g. rviewed on 02/02/22 at #4 stated that he had been at ber 2021 and "nighttime in vorst." He stated that the elled and cussed him a lot. Is paralyzed in a car accident bad back spasms which been he did not get his ined that at home he had a or his medicines that allowed coverage for his spasms but I not get that coverage ions were just given		medication for resider Administrator provided MA #1 on speaking to dignified manner. The facility failed to tredignified manner by no incontinence are when double, triple briefing #5, resident #9, resid #11. On 2/11/22, resid incontinence care and How the facility will ide having the potential to same deficient practice.	at #4. On 3/7/22 dd 1:1 reeducation to residents in a eat resident in a ot providing requested and resident #3, resident tent #10 and resident dents received d single briefed. entify other residents to be affected by the se;		
	and stated he had ce	nient for the staff. He nat occurred on 12/29/21 Il phone video footage of the at Medication Aide (MA) #1		Effective 3/14/2022 th Nursing and/or design incontinent residents t incontinence care pro	nee reviewed current to ensure		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING	·		
		345128	B. WING		02/23	/2022
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/20	72022
				520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES\	/ILLE				
				STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	Continued From page	÷ 3	F 55	0		
	was so rude to him ar	nd yelled and cussed at him		are not double or triple briefed. N	О	
		another nurse "came to my		additional concerns identified.		
		im get his medications that				
		ne had reported the incident		Effective 3/14/2022 the Director of	of	
		nd her response was "I will		Nursing and/or designee complet	ed an	
	check into it," he also	stated that he had reported		observation of license nurses and	t l	
	it to the former Directo	or of Nursing (DON) #2, but		medication aides during medication	on pass	
	he was only in the fac	cility for a couple of weeks		to ensure current residents are tre	eated in	
	and did not have time	to follow up about the		a dignified manner. No additional		
	incident. Resident #4	stated that the way MA #1		concerns identified.		
	spoke to him was terr	ible and he did not				
	appreciate it, all he w	anted his medications.		Address what measures will be p	ut into	
				place or systemic changes made		
	Review of cell phone			ensure that the deficient practice	will not	
		Resident #4 was reviewed.		recur:		
		A #1 at the medication cart				
		s wheelchair. Resident #4		Effective 3/24/2022 Director of Nu	-	
		h MA #1 and request his		and/or designee educated curren	•	
	_	There was a discussion		and agency Certified Nursing Ass		
	about his medication			and License Nurses on ensuring		
		wait on your medications		receive incontinence care as nee		
	-	e" and walked away from the		are not double or triple briefed, an		
		1 was heard using profanity		residents are spoken to in a digni		
		o another resident's room.		manner when requesting/receivin	ig	
		ed to approach Resident #4		medications.		
	_	beside MA#1's medication		Efforting 2/24/2022 and fortility and		
		dent #4 what he needed, he for his nighttime medication.		Effective 3/24/2022 any facility or	•	
		saying "it is 10:30 PM you		Certified Nursing Assistances and Nurses that have not been educated the control of the control		
				not be allowed to work until educa		
	-	edication yet" to which nat he had asked for it, but		received in- person or via telepho		
		nim. Nurse #8 and Resident		Director of Nursing and/or design	-	
	#4 stood by MA #1's i			during the orientation process.		
	approximately 5-10 m			dailing the offentation process.		
		t he was supposed to have		Indicate how the facility plans to r	monitor	
		heard telling Resident #4 to		its performance to make sure tha		
		ication cart and she would		solutions are sustained:	`	
	pull the medications t			25 data di a addunion.		
	-	A few minutes later Nurse #8		Director of Nursing will complete	visual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				С	
		345128	D. WING_			02/	/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT STATES	VII I F		5	20 VALLEY STREET			
710001121	00112/12/11/11/01/11/20	·		S	STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 550	Continued From page	e 4	F 5	550				
F 550	and Resident #4 returcart and Nurse #8 as the narcotic drawer for and Nurse #8 replied Resident #4's narcotic #8 calmy stated that I medication that were a right to have his me stated "he can wait like Nurse #8 was intervise PM. Nurse #8 stated incident on 12/29/21 mean to" Resident #4 working the other me nurse responsible for #8 stated she heard I around the corner, so see what was going to the side and asked had told her he asked that were due at 9:00 10:00 PM and Reside yelled at him and told Nurse #8 explained to was in pain and she wadministering his medication" and Nurse #4 for the rest of their she did report the incibut could not recall would address it.	rned to MA #1's medication ked MA #1 to please open or her. MA #1 asked why, she was going to pull to that he requested. Nurse he had requested his due at 9:00 PM and he had edication. MA #1 again ke everyone else."	F &	550	observations for non-interviewable residents and questionnaire for interviewable residents. Monitoring as follow: 5 residents weekly x 12 weeks the ensure residents are treated in a dignific manner. Results of these audits will be reviewed Monthly Quality Assurance Meeting X for further problem resolution if needed Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	ied d at 3		
	MA #1 explained that	she used to work the night rst of January she had						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 550	medications but alw responsible for over cart. MA #1 explains approached her whi cart requesting their me anxious, and I m done" with the one I seem to want their me stated that she recase she stated Resident medications. She st lashed out at me" but medications right the residents have feeling days" but I don't tak took care of Residents. Residents humans, with respected to talk nice not cuss at them. M Resident #4 and state him or any other residents with I at 1:46 PM. She state any incident with M/12/29/21. She state from 12/22/21 throutents.	e medication cart passing ays had a nurse that was seeing her on the medication ed that a lot of residents le she was on the medication medications and "that makes hake them wait until I get am working on, but they medication right then. MA #1 lled the incident on 12/29/21 #4 was requesting his ated that he "was upset and ecause he wanted his en. MA #1 stated that all higs and "not all days are good e it personal. She stated she in #4 like she did all her is should be treated like of and we the staff are ely to the resident and should A #1 denied cussing at ted she was never rude to ident that she cared for. was interviewed on 02/10/22 ted that she was not aware of A #1 and Resident #4 on did that she was on vacation gh 01/02/22 and Nurse #10 rewhile she was out so maybe	F 55		
	Nurse #10 was intel PM. Nurse #10 state incident to her regal She stated that she had reported the inci- he was in the facility	viewed on 02/10/22 at 1:50 ed that no one reported any rding MA #1 and Resident #4. did know that Resident #4 eident to former DON #2 while but was not sure exactly ly that it was reported to him.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C 23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE	•	520 V	ET ADDRESS, CITY, STATE, ZIP CODE ALLEY STREET FESVILLE, NC 28677	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 550	1:54 PM. The DON facility for a short tir Resident #4 had reshift staff were mean hollered and cussed was afraid to take in stated that Residen names and he did in specific names but general. He added specific incident #4 stated we needed it and we asked, she stated in The former DON #2 Resident #4 was reshe had reported it to done all he could done all he could done all he could done all he could done incident #4. 2. Resident #3 was 12/07/20. Review of the signiff Set (MDS) dated 12 #3 was cognitively it assistance with toiled significance with toiled significance in the signiful set in	s interviewed on 02/10/22 at stated that he was only at the me but while he was there corted to him that the night in to him and that they did at him all the time and he nedication from them. DON #2 at #4 did not mention specific not ask Resident #4 for reported the night shift staff in the was not made aware of any lluding the incident on rences in general. DON #2 reported to the Administrator Resident #4 had reported. That he had video footage if then the Administrator was of we did not need the video. It stated that he felt like what porting was verbal abuse, but to the Administrator and had	F	550				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 2/23/2022	
	ROVIDER OR SUPPLIER	TESVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	•		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	conducted on 02/0 At 7:06 AM Resid be on. At 7:31 AM the hallway stating need to be change was observed reshis brief and state changed. Resider feces and was alsplace. Resident # then my clothes dithem so long to cometime hours bistated that he did because it makes keeps me from ruthrough them. At 8 was observed to 6 Resident #3 state been waiting an histated that Resident # buttock and provide A follow up intervion 02/03/22 at 10 she had no idea Funtil she carried him up to eat his bett takes so long to through his brief, in the control of the company to the carried him up to eat his bett takes so long to through his brief, in the control of the control of the carried him up to eat his bett takes so long to through his brief, in the carried him up to eat his better the control of the carried him up to eat his better the carried him up to eat his bet	ervation and interview were 02/22 from 7:06 AM to 8:42 AM. ent #3's call light was noted to I Resident #3 was heard from g, "I need some help in here, I ed." At 8:32 AM Resident #3 ting in his bed, he had opened d that he needed to be at #3 was visibly soiled with so noted to have 2 briefs in 3 stated, "if I have 2 briefs on on't get wet" because it takes ome in and change me between changes. Resident #3 not like having 2 briefs on him feel "bad" but at least it ining my clothes when I wet 3:42 AM Nurse Aide (NA) #7 enter Resident #3's room and d "I need to be changed I have our and half for help." NA #7 ent #3 often had on 2 briefs and on occurrence" and proceeded 3 onto his side to wash his ded incontinence care. ew was conducted with NA #7 each face with the set of the care to him and then set oreakfast. NA #7 again stated on for Resident #3 to have 2 night shift because he reported get cleaned up and if he wet he would ruin his clothes.	F	550			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	UZI	23/2022
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	The DON explained to increase the frequenchecks considering the resident. By doing this the residents incontinuous at the same time waiting over an hour and acceptable and not briefs at one time. 3. Resident #9 was reconfully 1/20. Review of the annual dated 01/12/22 reveat cognitively intact and bowel and bladder and assistance with toileting the conducted with Resident 10:23 AM to 10:45 AN observed to turn his conducted with Resident 10:23 AM. He stated since before breakfast changed, they told him after breakfast. Resident #9 to the could. At Resident #9's room to NA #7 was observed standing position and that was soiled with fe heavy. Resident #9 were resi	het don 02/07/22 at 3:40 PM. hat facility staff would have ency of their incontinence he individual needs of each is the facility wound ensure ence needs were met in a lake care of the any dignity e. The DON stated that for incontinence care was leither was wearing multiple admitted to the facility on Minimum Data Set (MDS) led that Resident #9 was was always incontinent of ad required extensive ing. Attion and interview were lent #9 on 02/02/22 from M. Resident #9 was call light on for assistance at that he was wet and soiled at but when he asked to be in he would have to wait until lent #9 stated that after the did up around 9:00 AM he told	F	550			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	area to ensure he won his buttocks was scrubbing the dried to NA #7 that before PM he would like fo because it would be changed again and clothes. Resident # "low" like less of ma with 2 "diapers on." wearing multiple bri have?" A follow up interview on 02/03/22 at 10:4 she arrived at work requested to be chasoon as breakfast a provided as request providing incontiner "cross contaminatio time she was able to 10:45 AM. She state could do." She adderequested to have 2 because it would be changed again and NA #7 stated that if briefs on then she put the DON explained to increase the frequesident. By doing to the residents incontained in the providents of	vas clean. Resident #9's skin intact and slightly red from feces off. Resident #9 stated at the end of her shift at 3:00 or her to put 2 briefs on him a while before he got did not want to ruin his 9 stated that it made him feel in to have sit his own waste. He added he did not like efs but "what other choice do I was conducted with NA #7 6 AM. She stated that when at 7:50 AM Resident #9 inged and she told him as so over, care would be seed as she had been told that fince care during mealtime was in." NA #7 stated that the first to get to Resident #9 was at ed, "I was doing the best I ed that Resident #9 frequently a briefs and he said it was a while before he got didn't want to ruin his clothes. Resident #9 asked to have 2	F 55			

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 550 Continued From page 10 waiting over an hour for incontinence care was not acceptable and neither was wearing multiple briefs at one time. The Administrator stated that when care was requested it should be provided STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLET DATE) PREFIX TAG F 550 F 550 F 550 F 550 STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677 F 550 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACT			345128	B. WING _				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 10 waiting over an hour for incontinence care was not acceptable and neither was wearing multiple briefs at one time. The Administrator stated that when care was requested it should be provided PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 F 550 F 550			SVILLE		520 VALLEY STREET		1 02/2	
waiting over an hour for incontinence care was not acceptable and neither was wearing multiple briefs at one time. The Administrator stated that when care was requested it should be provided	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	((EACH CORREC CROSS-REFEREI	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA	I	(X5) COMPLETION DATE
4. Resident #10 was readmitted to the facility on 03/01/05. Review of the quarterly Minimum Data Set (MDS) dated 01/09/22 revealed that Resident #10 was cognitively intact and required limited assistance with toileting. The MDS further revealed that Resident #10 was occasionally incontinent of bowel and bladder. A continuous observation and interview were conducted with Resident #10 on 02/02/22 from 7:06 AM to 8:15 AM. At 7:06 AM it was noted that Resident #10's call light was on. At 7:26 AM Resident #10's call light was on. At 7:26 AM Resident #10's stated that she needed to be changed, she stated she could not see the clock on the wall because it was too dark to know what time she turned the call light on. She stated she had been asleep and woke up and could tell that she was wet and turned the call light on. At 7:29 AM Nurse #10 entered Resident #10's room and turned the call light off and exited the room and continued down the hallway. At 7:35 AM Resident #10 again stated she needed to be changed, "I guess I better turn my light back on" and she did. At 8:15 AM Nurse #11 was observed to enter Resident #10's room and change her brief. The brief was heavily saturated with urine and when thrown into the trash can made a loud thud noise. A follow up interview was conducted with Resident #10 to 20/2/22 at 9:24 AM. Resident #10 stated that she had turned her call light back	F 550	waiting over an hour not acceptable and r briefs at one time. T when care was requ without delay includi 4. Resident #10 was 03/01/05. Review of the quarted dated 01/09/22 reveloritively intact and with toileting. The Min Resident #10 was obowel and bladder. A continuous observe conducted with Resident #10's call lift Resident #10's call lift Resident #10's call lift Resident #10 stated changed, she stated on the wall because time she turned the changed had been asleep and she was wet and turn AM Nurse #10 enter turned the call light continued down the #10 again stated she guess I better turn mat 8:15 AM Nurse #7 Resident #10's room brief was heavily sat thrown into the trash A follow up interview Resident #10 on 02/	refor incontinence care was neither was wearing multiple. The Administrator stated that ested it should be provided ing during mealtimes. Freadmitted to the facility on serly Minimum Data Set (MDS) alled that Resident #10 was direquired limited assistance DS further revealed that coasionally incontinent of set was an administration and interview were dent #10 on 02/02/22 from and an attention and interview were dent #10 on 02/02/22 from and attention and attention and that ight was on. At 7:26 AM that she needed to be she could not see the clock it was too dark to know what call light on. She stated she did woke up and could tell that need the call light on. At 7:29 ed Resident #10's room and hallway. At 7:35 AM Resident eneeded to be changed, "I my light back on" and she did. It was observed to enter an and change her brief. The curated with urine and when a can made a loud thud noise.	F5	550			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER	/ILLE	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	makes me feel bad for is that I wet myself and to have someone char to have someone care to light was on but state had been on. Nurse # working as a Nurse A had some agency stathat left them in a bind night and into the modo every 2-hour incort the best we can." Nurse #10 was interved. Nurse #10 confires Resident #10's call light stated she had let the care. Nurse #10 could reported to but stated on the hall know that requesting care. The Administrator and (DON) were interview. The DON explained to increase the frequency checks considering the resident. By doing this the residents inconting timelier fashion and the same time waiting over an hour in not acceptable. The Acall light should be tut the need of the residents.	came to change me, which or 2 reasons." "One reason and the second is that I have unge me, I am not a child." dewed on 02/02/22 at 8:25 med that he had provided Resident #10 because her do he had no idea how long it that stated that he was ide that night because they fit that did not show up and do. He added that during the raining they were not able to ontinence checks but "we do itewed on 02/02/22 at 5:45 med that she had turned off ght earlier that morning but a NA know that she needed do not recall which NA she she let the direct care staff	F	550			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345128	B. WING			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	I	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From pa	=	F 5	50		
	be provided without	delay.				
		s admitted to the facility on tly readmitted on 01/16/22.				
	(MDS) dated 02/02 #11 was cognitively assistance with toile revealed that Residincontinent of bower Resident #11 was in AM. Resident #11 she turned her call cell phone) and the talked to them for a with her family Resistayed on and no of assist her. She state PM when she turned the phone with her light was still on, and family member told.	are 5-day Minimum Data Set //22 indicated that Resident intact and required extensive eting. The MDS further ent #11 was always I and bladder. Interviewed on 02/04/22 at 9:33 stated that last night (02/03/22) light on at 7:30 PM (time on a she called her family and while. While on the phone ident #11 stated her call light ne from the facility came in to ed that she was wet at 7:30 d her call light on and while on family at 10:30 PM her call id she remained wet. The Resident #11 that she was illity and see if she could get				
	some help for her, a Resident #11 stated member continued family member aga got no answer. The was going to call th wellness check. Re hung up with her fa 11:00 PM so the fan police. Resident #1 11:00 PM the staff of they were assigned	and she did but got no answer. If that she and her family to talk for a bit longer and the in called the facility and again family member decided she e local police department for a sident #11 stated that she mily member a little before mily member could call the 1 stated that shortly after came in and explained that to the other side of the ently the staff for the side of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 550	shown up for work. had been in to assi that they were there stated that when the soaking wet all the while the staff mem assisting her the postick around. Reside me feel so bad and lay in my own wast. NA #3 was interview NA #3 confirmed the shift at the facility of who was assigned but stated that around were asked to go at the building because shown up. NA #3 the unit where Resident #11 needs she had been waiting several hours. She very wet and had a brief. NA #3 stated Resident #11 the potime, they had come the police were gor. The Administrator as (DON) were intervied to increase the free checks considering residents. By doing the residents incontimelier fashion. The	They apologized that no one st Resident #11 and stated at to assist her. Resident #11 as staff changed her, she was way to the pad on the bed and abers were in the room plice showed up but did not lent #11 stated that "it makes it is so demeaning to me" to lent #11 stated that "it makes it is so demeaning to me" to lent #11 stated that "it makes it is so demeaning to me" to lent #11 stated that "it makes it is so demeaning to me" to lent #11 stated that mozional stated the night in 02/03/22. She was not sure to take care of Resident #11 and 12:30 AM she and NA #1 and check on the other side of set here was staff that had not lated that when they went to ident #11 resided her call light lent lent be changed and stated and on someone to help her for stated that Resident #11 was small amount of feces in her that while they were assisting olice showed up but by the pleted care with Resident #11	F 5.	50	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER	ESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	T VEILOILULE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 550	acceptable and shot Administrator state police were called a She also stated who was the expectation without delay. 6. Resident #5 was 04/14/16. A review of Reside 08/10/21 revealed and bowel due to othe the would remarked to incontine attained by utilizing place call light with care after each epineeded and apply. The quarterly Minimassessment dated was cognitively intarejection of care. The sident required with bed mobility and bowel. During an interview #5 on 02/04/22 at 9 explained that he wowel and needed.	age 14 for incontinence care was not could not have occurred. The dishe was the aware that the and responded to the facility. It is a resident requested care it in that the care be provided. In that the care be provided In that the care plan dated the was incontinent of bladder decreased sensation. The goal win free of skin breakdown there and brief use would be interventions that included in reach, provide incontinent sode of incontinence and as briefs for incontinence. In that the care be provided In the was incontinent of bladder decreased sensation. The goal win free of skin breakdown the sode of skin breakdown that included in reach, provide incontinent sode of incontinence and as briefs for incontinence. In that the care be provided I	F 55			
	staff would only chand the last time ho third shift left that n continued to explai	ange him about twice a day e was changed was before norning. The Resident n that the night shift nurse aide which aide) asked him if he				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			1	23/2022
	ROVIDER OR SUPPLIER	l		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677	0212	23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	told her to put three of not check and change the time they would in he needed to be chart that he was currently (Surveyor verified he because he felt the thim from soaking his that sometime the thim from soaking his sheet embarrassing enough wear one brief but who briefs at a time to keet he felt degraded. On 02/04/22 at 12:15 Resident #5 he stated be changed. On 02/04/22 at 12:18 Nurse Aide #9 who with the washift and reported be changed. During that shift and reported be changed that Resident #5 after profiber of the with urine and stool. Resident #5 after profiber of the world put more than time. The NA continues he was supposed to incontinent residents needed but it was an	two or three briefs and he in him because the staff did in him regularly and most of ot answer his call light when inged. The Resident stated wearing three briefs was wearing three briefs was wearing three briefs him bed. The Resident stated ee briefs did not prevent him interest. He explained that it was in for a grown man to have to be the had to wear three in form soaking his sheets, PM during an interview with the did he was wet and needed to interest to he procedure the NA esident #5 was wearing rest two briefs were soiled. The NA applied one brief on widing incontinent care.	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIEICATION NILIMPED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING			1	C 23/2022
	ROVIDER OR SUPPLIER	VILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	was the first time she incontinent care on the and stated she worked there was not enough care on the residents the residents three m. The nurse aide who pare Resident #5 was unated and changed was done, then he we three briefs and the Federaded. The Admir facility was looking in staffing agency to impare She stated that her expected every two hours. Self-Determination CFR(s): 483.10(f)(1)-\$483.10(f) Self-determination control imited to the right (1) through (11) of thi \$483.10(f)(1) The residents activities, schedules (waking times), health	was able to provide the Resident during her shift d as fast as she could but a staff to provide incontinent every two hours and feed the three briefs on the to be identified. With the Director of Nursing ator on 02/07/22 at 3:40 PM that Resident #5 should be devery two hours and if that build not feel forced to wear the sident would not feel distrator explained that the to hiring a more reliable prove the staffing situation. Expectation was that the and changed if needed (3)(8) Initiation. Initiation.		550			3/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345128	B. WING_		C	
NAME OF P	ROVIDER OR SUPPLIER	040120	1	STREET ADDRESS, CITY, STATE, ZIP CODE	02/23/2022	
TVAINE OF T	TOVIDER OR OUT FIELD					
ACCORDI	US HEALTH AT STATES\	/ILLE		520 VALLEY STREET		
				STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 561	F 561 Continued From page 17		F 50	51		
	applicable provisions of this part.					
		ident has a right to make s of his or her life in the cant to the resident.				
	with members of the	ident has a right to interact community and participate in both inside and outside the				
	religious, and commu interfere with the right facility. This REQUIREMENT by: Based on observation	ident has a right to tivities, including social, nity activities that do not ts of other residents in the is not met as evidenced ns, record reviews and staff ws, the facility failed to		How corrective action will be accomplished for those residents	found to	
		uest to get out of bed at his for 1 of 1 resident reviewed #5).		have been affected by the deficient practice;	nt	
	The finding included:			The facility failed to honor a residence request to get out of bed at prefer of day.		
	with diagnoses that in intracerebral hemorrh			Resident #5 request was honored 2/11/2022 and care plan/task list to reflect resident preferred time of	updated	
		/24/21 revealed Resident #5		in/out of bed.		
	rejection of care. The	and had no behaviors of MDS also indicated the dependent on staff with 2 nsfers and required a		How the facility will identify other having the potential to be affected same deficient practice;		
	wheelchair for mobility	•		Effective 3/14/2022 the Director o Nursing and/or designee complete questionnaires with current cognit	ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			02/	23/2022	
NAME OF PE	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	021	ES/EUZE	
	10 115211 011 001 1 21211				20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE						
				S	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	Continued From page	e 18	F	561				
	Resident #5 had a se in his activities of dail limited mobility and ri-Resident #5 to mainta would be met by utilizincluded transfers wit persons assist and ut wheelchair with a right On 02/04/22 at 12:15 and interview with Rehe liked to get out of pointed to a sign which his request that state before lunch". The Rethat he had not been month because the sinot enough staff to ge was in the middle of a residents had to stay continued to explain twheeling up and dow masks and he would mask.	If-care performance deficit y living (ADL) related to ght hemiplegia. The goal for ain his current ADL function ting interventions that h a mechanical lift and two illizing a high back reclining at foot pedal. PM during an observation esident #5 he explained that bed before lunch and the was posted on the wall at d "I choose to get up daily esident continued to explain out of the bed for over a taff told him that there was et him up and that the facility a COVID outbreak so the in their rooms. The Resident that he could see residents in the hall while wearing their be agreeable to wearing a		501	intact residents and with resident representative for cognitively impaired residents to ensure preferred time for getting in/out of bed is being adhered to Care plan/task list updated as indicated for resident preference. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur: Effective 3/24/2022 Director of Nursing and/or designee educated current facili and agency Certified Nursing Assistance and License Nurses on ensuring reside choices are being honored. Effective 3/24/2022 any facility or agence Certified Nursing Assistances and Licen Nurses that has not been educated will not be allowed to work until receive education in- person or via telephone bedirector of Nursing and/or designee as part of the orientation process.	ty ces ents		
	Nurse Aide (NA) #9 w Resident #5 and repo like to get out of bed. Resident's room and his personal wheelch hallway. The NA expl there was no wheelch	orted that the Resident would			Effective 3/24/2022 newly hired facility and agency certified nursing assistance and licensed nurses will receive education during orientation and prior to working. Indicate how the facility plans to monitor its performance to make sure that	0		
	the room. The NA car room and reported the wheelchair to get him	me back into the Resident's at she could not find his			solutions are sustained: Director of Nursing and/or designee wil audit (5) residents to ensure choices ar being honored 3 X week X 4 weeks,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 02/23/2022	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.20	<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022
TWAINE OF TH	TO VIDER OR OUT FILER						
ACCORDI	US HEALTH AT STATES	VILLE	520 VALLEY STREET		TATESVILLE, NC 28677		
	OLUMBA DV OT	ATEMENT OF RESIDIENCES					1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 561	561 Continued From page 19		F 561				
		45 PM. The NA explained			weekly X 4 weeks, and bi-weekly X 4		
		are of Resident #5 and she			weeks.		
	had not gotten him up	o out of bed or seen him out					
		NA continued to explained			Results of these audits will be reviewed		
	·	ired a mechanical lift and			monthly Quality Assurance Meeting X		
		and most of the time the			for further problem resolution if needed		
	•	taffed that the aides only d change the incontinent			Director of Nursing will review the result of weekly audits to ensure any issues	IIS	
		e residents their meals.			identified are corrected.		
	rootaonto ana rooa tri	o rodiadrito trion modio.			laonima are corrected.		
	An observation of Re	sident #9 on 02/04/22 at			Completion date: 3/25/2022		
		Resident remained in bed					
		e Resident's wheelchair was					
	not in his room, bathr	oom or the hallway.					
	_	vith the Administrator and					
		OON) on 02/07/22 at 3:40 explained that the residents					
		se when they wanted to get					
	_	cility should honor Resident					
		of bed when he desired.					
	The Administrator add	ded, they would continue to					
	look for Resident #5's						
F 580 SS=K		jury/Decline/Room, etc.))(i)-(iv)(15)	F :	580			3/25/22
		ediately inform the resident;					
		ent's physician; and notify, her authority, the resident					
	representative(s) whe						
	(A) An accident involv	ring the resident which					
		as the potential for requiring					
	physician intervention						
	, , -	ge in the resident's physical,					
	mental, or psychosoc						
		n, mental, or psychosocial reatening conditions or					
	Status III oluloi IIIo-uli	Satering Conditions of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 OEIZOIZOEZ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 580	a need to discontinue treatment due to advocommence a new for (D) A decision to transcribe tresident from the facility and the facility of this section, all pertinent informatics available and proving physician. (iii) The facility must a resident and the resid	eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or usfer or discharge the elity as specified in effication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ided upon request to the elitor also promptly notify the elent representative, if any, an or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph in the electron and periodically mailing and email) and resident elitor, including the various see the composite distinct to, including the various see the composite distinct to the policies that apply to en its different locations.	F 58	How corrective action will be		
	Nurse Practitioner (N	P) and Physician (MD), the		accomplished for those residents four	nd to	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	J. 0930 - 0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED	
							С
		345128	B. WING			02	/23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD!	IIIO UEALTU AT OTATEO	VII I E		52	20 VALLEY STREET		
ACCORDI	IUS HEALTH AT STATES	VILLE		S	TATESVILLE, NC 28677		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	` ,	
PREFIX TAG	,	:Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 580	Continued From pag	e 21	F	580			
1 000	-			360	have been affected by the deficient		
	facility failed to notify	st/ International Normalized			have been affected by the deficient		
		atory (lab) tests that were not			practice;		
		d. The facility also failed to			The facility failed to notify the provider		
		6 PT/INR laboratory results			when a physician's order for obtaining		
	that were outside of t	_			scheduled PT/INR labs was unable to	be	
	parameters of 2.0 to	3.0. Resident #1 was			drawn and failed to notify the medical		
	1 -	22 for a ruptured abdominal			provider of PT/INR levels outside the		
	hematoma with visible	e oozing of blood and was			given parameters of 2.0- 3.0 for Reside	∍nt	
	1	atherapeutic (elevated)			#1.		
	•	arrival. This was for 1 of 1					
	resident reviewed for				On 2/3/22, the licensed charge nurse		
	(anticoagulant-oral b	,			notified the nurse practitioner of Reside		
		acility also failed to notify the			#1 missed PT/INR labs between 12/17	/21	
	· ·	vere unable to provide when Nurse # 16 failed to			and 1/24/22 and discussed		
		ns because she did not			On 2/7/22, the MDS nurse updated		
		esided on her unit for 2 of 2			Resident #1 anticoagulant therapy care	ے	
		#14 and Resident #15) and			plan to include monitoring for adverse	•	
	failed to provide a nig	•			side effects: discolored urine, black tar	ry	
		or neglect (Resident #15).			stools, sudden severe headache, N&V	-	
		,			diarrhea, muscle joint pain, lethargy,		
	The immediate jeopa	rdy began on 12/17/21 when			bruising, sudden changes in mental sta	atus	
	•	otify the provider of PT/INR			and/or vital signs, SOB or nose bleeds		
		mpleted as ordered. The			Care plan also includes notification to		
		was removed on 2/8/22 when			physician/nurse practitioner of all PT/IN		
		and implemented a credible			results and of any adverse side effects	to	
		ate jeopardy removal. The			anticoagulant drug use.		
		of compliance at a lower			How the facility will identify other resid	onto	
		f E (no actual harm with an minimal harm that is not			How the facility will identify other resident having the potential to be affected by the state of the state o		
	1 -	to ensure education is			same deficient practice;	10	
		oring systems put into place			camo denoient praenee,		
	are effective.	and officering bat into biago			Residents with scheduled PT/INR lab		
					orders are at risk of the Physician/Nurs	e	
	The facility was cited	at F-580 for example #2 and			Practitioner not being notified of labs		
	3 at a scope and sev				results that are not obtained as ordere	t	
					and lab levels not within their therapeu	tic	
	Findings included:				levels. Therefore, effective 2/7/22, the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 02/23/2022	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG			NCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SE		HOULD BE	(X5) COMPLETION DATE	
F 580	10/21/21 and most re 12/16/21 with diagnor acute embolism and the lower extremity. According to the hos dated 12/16/21, Resiper PT/INR therapeutic roward the responsibility of the therapy. A Physician's order of PT/INRs were to be anticoagulant usage. A review of the daily Resident #1 from 12/17 revealed the followin - There were no PT/I of the 27 dates that F (12/17/21, 12/19/21, 12/28/21, 12/30/21, 1/9/22 through 1/11/2 There was no docum Provider was contact labs were not obtaine - There were 6 PT/IN of the therapeutic rare 6.32, 12/25/21 - 3.29 4.47, 1/7/22 - 5.24, and documentation to notified of these PT/I the provided parame	nitted to the facility on ecently readmitted on ses of atrial fibrillation and thrombosis of deep vein of pital discharge summary dent #1 was to maintain a ange of 2.0 to 3.0 while on lated 12/17/21 indicated daily obtained due to PT/INR laboratory results for 17/21 through 1/13/22 g: NR laboratory results for 15 PT/INRs were ordered 12/22/21, 12/23/21, 1/1/22 through 1/6/22, and 22) in the medical record. Itentation to indicate the led and made aware these ed. IR results that were outside ling of 2.0 to 3.0 (12/24/21 - 1, 12/26/21 - 3.31, 12/31/21 - 1 and 1/8/22 - 4.59). There was indicate the Provider was NR results which fell outside ters for Resident #1.	F 58	Interim Director of Nursing and charge nurse reviewed current for residents with orders for PT/INF ensure labs are being obtained ordered and that failure to obtain ordered and PT/INR levels outs given parameters are reported to Physician/Nurse Practitioner. Or additional resident identified with results outside given levels not additional resident identified with results outside given levels not additional resident identified with results outside given levels not additional resident identified with results outside given levels not additional resident identified with results outside given levels not additional resident identified with results outside given levels not additional resident identified with results outside given levels not additional resident for additional resident flowers and reperties and reperties and reperties and reperties and reperties and reperties and reperties. Address what measures will be place or systemic changes madensure that the deficient practical recur: On 2/7/22, the Director of Regularity Risk Management provided eduate Administrator, Interim Direct Nursing, SDC (Staff Developme Coordinator) and Licensed Chankurses on the lab process for resident in the process of the corresponding lab results, sub/supratherapeutic levels, siguing coumadin toxicity, treatment for drawing blood samples for PT/II requisitions to contracted lab process for reporting to nurse supervisor for the process of the corresponding to nurse supervisor for the process for responding to nurse supervisor for the process for the process for proce	acility R labs to as In labs as I		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG _		, ا	C
		345128	B. WING				23/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
A C C O D D I	HO HEALTH AT CTATEC	VIII I E		52	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		s	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page An interview was con Practitioner (NP) on the reported that on administration parameters for Residexplained that general levels between 2.0 to residents on Coumact to be notified of any in the set parameters of that these parameters of that these parameters coumadin dosing. The NP reported she PT/INR results in the multiple results that we explained that she set system herself in an explained that she set system herself in an explained that she set system herself in an explained that were not obtained t	<u> </u>		580	options to obtain the sample as ordered and reporting all lab results and labs the are unable to be obtained as ordered to the Physician/Nurse Practitioner. Effective 3/24/22, the Director of Nursing and Licensed Charge Nurses provided education to current facility and agency licensed nurses on lab process for residents on coumadin therapy. Newly hired agency and facility licensed nurses will not work until education received during the orientation process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator or Director of Nursing will monitor residents with PT/INR order to ensure compliance with obtaining, monitoring and notification to the Physician/Nurse Practitioner is completed to the ensure times weekly x 12 weeks. Results of these audits will be reviewed monthly Quality Assurance Meeting X of for further problem resolution if needed Director of Nursing will review the result of weekly audits to ensure any issues identified are corrected.	at o ng / es ted d at 3	
	PT/INR results on 12 or 12/31/21; however supratherapeutic PT/ would make alteratio	/24/21, 12/25/21, 12/26/21,			Completion date: 3/25/2022		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			02/2	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, 520 VALLEY STREET STATESVILLE, NC 28			2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	PT/INR she discovered obtained on 12/24/21 was restarted on 12/2 other alterations made that corresponded to Resident #1. A review of PT/INR la Mondays and Fridays 1/13/22 through 1/26/2 There were no PT/IN the 4 dates that PT/IN 1/17/22, 1/21/22, and record. There was nothe provider was continued in the provider was an owhere they did not all to perform venipuncturained on how to do sindicated he worked wand noticed the order Supervisor or the Prothe ordered PT/INR late to obtain the lab to the An interview on 2/3/2: Medication Aide (MA: medication cart on 1/2 noticed the order for PT/INR drawn on her not qualified to perform Nursing Supervisor was restarted to 1/2 to 1/2 to 2/3/2 to 1/2 to 2/3/2 to 2/3	andary to an abnormal and herself for a lab that was and anticoagulant therapy (6/21, but there were no are to the Coumadin therapy these abnormal PT/INRs for aboratory results ordered for for Resident #1 from 22 revealed the following: NR laboratory results for 4 of IRs were ordered (1/14/22, 1/24/22) in the medical documentation to indicate acted and made aware btained. 2 at 1:00 PM with Nurse #2 ut of state agency nurse ow licensed practical nurses are and had not been so by facility staff. He further with Resident #1 on 1/2/22, but he did not notify a shift wider of his inability to obtain ab but reported the inability e oncoming shift. 2 at 2:53 PM with #1) revealed she worked the 1/22. She indicated she Resident #1 to have a shift, but she knew she was me the task and felt like the ould have known the lab therefore she did not notify	F	580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022		
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	DDE	VEL EST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	DATE		
F 580	#3 revealed she had not have supplies to had been times wher provider had not showere not made award Nurse #3 stated she 1/3/22 and 1/14/22 a MD/NP when she was cheduled PT/INR of PT/INRs for Residen specifics for each darmare and the facility with Residual 12/23/21 and stated labs in the facility on supplies such as tour Nurse #20 verbalized (12/22/21) when the company would not stays when they were always know they had therefore didn't know Nurse #20 stated she when she was unable PT/INR or of any abruth. An interview on 02/10 #1 revealed she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing. Nurse #20 stated she was she had been unable to lack of butterfly ne Nurse #20 indicated been made aware, bongoing.	B/22 at 11:40 AM with Nurse times when the facility did draw ordered labs and there in the outside contracted lab win up to draw labs, but staff the the lab was not drawn. Worked with Resident #1 on and she did not notify the las unable to obtain the rof any abnormal lab the the standard was unable to recall the. 12 at 7:23 PM with Nurse #20 rised as an agency nurse at lent #1 on 12/22/21 and she was not able to draw 12/23 due to the lack of miquets and lab tubes. If there were also times outside contracted lab show up on the designated escheduled, and staff did not	F	580				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP 520 VALLEY STREET STATESVILLE, NC 28677	CODE	02/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	DATE.
F 580	assigned to Residen and 1/9/22 when she lab provider obtained PT/INR's as well as of Resident #1 had supshe did not report the Provider. A hospital discharge revealed Resident #1 Room (ER) around 1 ruptured abdominal I of blood. He was fou supratherapeutic PT. The area on the right began to bleed with a pressure during initial which time the ER ple potential of a life-threvitamin K, and admit hospital's intensive of stabilized and discharge revealed Resident #1 ER via EMS but short facility on 1/28/22. See readmission, he was toilet at the facility are sensation in his abdot bleeding from the sate EMS, he was felt to 1 cc of blood. Given the to stop the bleeding Resident #1 was adrintensive care unit.	se #1 acknowledged she was it #1 on 12/17/21, 12/30/21, in or the outside contracted it Resident #1's ordered on 1/7/22 and 1/8/22 when was ratherapeutic PT/INRs which is abnormalities to the summary dated 1/28/22 in arrived at the Emergency 1:00 PM on 1/26/22 for a mematoma with visible oozing and to have a visible oozing and to have a visible of the significant decrease in blood and attempts at imaging at mysician felt this to be a meatening emergency, given atted Resident #1 to the are unit. Resident #1 was arged to the facility on summary dated 02/03/22 in was transferred back to the artly after readmission to the econdary to shortly after his transferring from chair to the one site. Upon arrival of mave lost approximately 300 ese findings and the inability from direct pressure,	F	580		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONST	RUCTION	(X3) DATE COMP	SURVEY
		345128	B. WING _				C 23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		520 VALI	ADDRESS, CITY, STATE, ZIP CODE LEY STREET VILLE, NC 28677	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	(NP) on 02/03/22 at 3 because of these ord Resident #1 had mult which resulted in hos abdominal surgery. The notified; she conhis Coumadin dosage rehospitalization. An interview on 02/03 revealed she expected as ordered and if the provider did not obtait expected facility staff to the local contracted MD indicated a Medic which should be maderesults or the inability seek further direction dosage or frequency MD stated she has has aff in the evening to believed it was the facontact the Provider in required to manually explained copies of a the Physician's contal labs should be called elaborated for the safe others on Coumadin receiving anticoagular monitored for adverse of the medication usa	ratory surgery. With the Nurse Practitioner 3:40 PM she indicated that ers not being followed, ciple elevated PT/INR levels pitalization with exploratory the NP indicated if she had all have potentially adjusted at to prevent his William 12:20 at 5:30 PM with the MD and nursing staff to obtain labs outside contracted lab in the lab as scheduled, she to obtain the lab and send it did hospital lab for results. The cal Provider was on-call 24/7 are aware of abnormal lab to obtain a scheduled lab to in the event the Coumadin needed to be adjusted. The add trouble contacting nursing of check on lab results and cility's responsibility to instead of the Provider being look up lab values. The MD labs were to be placed in ct binder, but all abnormal immediately. The MD fety of Resident #1 and therapy, all residents in therapy should be closely a reactions and side effects	F	580			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER	VILLE		5:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677	<u>CZII</u>	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	staff to monitor all restherapy to include: fol provider when labs at any lab results in an a resident's set parame. The Administrator was Jeopardy on 2/06/22. The facility provided to F580: Identify those or or likely to suffer, a seresult of the noncomp. The facility failed to nophysician's order for collabs was unable to be the medical provider of given parameters of 20.02. Resident #1 was adm 10/21/21 with diagnost and acute embolism at unspecified deep veir extremity. Physician conticoagulation theral requires lab monitoring ranges of 2.0 -3.0. Be 12/17/2021 - 1/24/2021 physician orders for Facility failed to obtain #1 based upon physic results for 6 days bett 12/31/21 and 13 days between the dates of Additionally, Residentifications.	wealed they each expected sidents on anticoagulant allow orders for lab, notify the re unable to be obtained or abnormal value outside the eters. Is notified of the Immediate at 10:25 AM. The following IJ removal plan. The following IJ removal plan.	F	580			

			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 29 1/10/2022 with no notification to physician or nurse practitioner. Subsequently, Resident #1 had a change in condition (bleeding) which required transfer to the hospital for treatment on 1/26/22. Hospital records revealed Resident #1 had a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival to the hospital. The resident continued to bleed from his abdomen which required stabilization in the intensive care unit. Resident #1 was stabilized and discharged back to the facility on 1/28/22 around 6PM with a subtherapeutic PT/INR of 1.28. Resident #1 required transfer back to the			345128	B. WING					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 29 1/10/2022 with no notification to physician or nurse practitioner. Subsequently, Resident #1 had a change in condition (bleeding) which required transfer to the hospital for treatment on 1/26/22. Hospital records revealed Resident #1 had a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival to the hospital. The resident continued to bleed from his abdomen which required stabilization in the intensive care unit. Resident #1 was stabilized and discharged back to the facility on 1/28/22 around 6PM with a subtherapeutic PT/INR of 1.28. Resident #1 required transfer back to the			ESVILLE		520 V	ALLEY STREET		OL/LO/LOLL	
1/10/2022 with no notification to physician or nurse practitioner. Subsequently, Resident #1 had a change in condition (bleeding) which required transfer to the hospital for treatment on 1/26/22. Hospital records revealed Resident #1 had a ruptured abdominal hematoma with visible oozing of blood. He was found to have a supratherapeutic PT/INR of 4.57 upon arrival to the hospital. The resident continued to bleed from his abdomen which required stabilization in the intensive care unit. Resident #1 was stabilized and discharged back to the facility on 1/28/22 around 6PM with a subtherapeutic PT/INR of 1.28. Resident #1 required transfer back to the	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE	
abdominal area which in turn required a surgical procedure to evacuate a large hematoma from Resident #1 abdomen. On 2/3/22, the licensed charge nurse notified the nurse practitioner of Resident #1 missed PT/INR labs between 12/17/21 and 1/24/22 and discussed the PT/INR levels outside of the given parameters of 2.0-3.0 for Resident #1. On 2/7/22, the MDS nurse updated Resident #1 anticoagulant therapy care plan to include monitoring for adverse side effects: discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, SOB or nose bleeds. Care plan also includes notification to physician/nurse practitioner of all PT/INR results and of any adverse side effects to anticoagulant drug use. Residents with scheduled PT/INR lab orders are	F 580	1/10/2022 with no nurse practitioner. had a change in corequired transfer to 1/26/22. Hospital rehad a ruptured aboozing of blood. He supratherapeutic Fithe hospital. The rehis abdomen which intensive care unit, and discharged ba around 6PM with a 1.28. Resident #1 hospital on 1/28/20 abdominal area whore practitioner of labs between 12/11 discussed the PT/I parameters of 2.0- On 2/7/22, the MD anticoagulant there monitoring for adveurine, black tarry sheadache, N&V, dilethargy, bruising, status and/or vital status and/	notification to physician or Subsequently, Resident #1 ondition (bleeding) which of the hospital for treatment on ecords revealed Resident #1 dominal hematoma with visible etwas found to have a pr/INR of 4.57 upon arrival to esident continued to bleed from a required stabilization in the Resident #1 was stabilized ext to the facility on 1/28/22 a subtherapeutic PT/INR of required transfer back to the polycolor of the properties of the polycolor of the polycolor of the polycolor of the polycolor of the given and the polycolor of the polycolor of the polycolor of the given and the polycolor of the polycolor o	F	580				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 580	as ordered and lab therapeutic levels. Interim Director of Nurse reviewed currorders for PT/INR la obtained as ordered as ordered and PT/parameters are repractitioner. One acwith PT/INR results documented as repas ordered. The lice Nurse Practitioner conitiated, anticoagul administration reconlicensed nurse to in	ge 30 s results that are not obtained levels not within their Therefore, effective 2/7/22, the dursing and licensed charge rent facility residents with abs to ensure labs are being d and that failure to obtain labs INR levels outside the given orted to the Physician/Nurse diditional resident identified outside given levels not being orted to the medical provider ensed charge nurse notified on 2/7/22. PT/INR flow record ant care plan and medication rd (MAR) updated by the clude monitoring for adverse orting to physician/nurse	F 58	30	
	process or system of adverse outcome from when the action will on 2/7/2022, the Action of Nursing, Regional Director of Regulated Medical Director co (Quality Assurance meeting to discuss facilities failure to en Physician/Nurse Proscheduled PT/INR I ordered and PT/INR parameters of 2.0-3 formulate plan of control of the control of the process of the control of th	dministrator, Interim Director all Director of Operations, ory and Risk Management and inducted an Ad Hoc QAPI Performance Improvement) proot cause analysis of the insure that the actitioner was notified of abs not being drawn as R levels outside the given 3.0 for Resident #1 and to interection to address this issue.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C)2/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		212012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Committee. It is detecause analysis that a failed to ensure that implemented, follower notification of PT/INF parameters and 2) licimplement PT/INR parameters were of the second provider where unable to be obtained to the parameters are also provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to be obtained the provider and reporting all laburable to parameters and provider and reporting all laburable to parameters and provider and reporting all laburable to parameters and providers and provide	of follow-up reviews by QAPI permined based upon root of the facility management the lab policy was ed, and monitored related to results outside of censes nurses failed to rocedure of notifying the en PT/INR blood samples obtained as ordered and when outside the given parameters in interviewing licensed reason for not following lab concludes; a) while Licensed ze process of notifying the unable to obtain a PT/INR as not provide a reason for not and b) while Licensed ze the process of notifying when PT/INR levels were rameters, they could not not following the process. For of Regulatory and Risk ed education to the in Director of Nursing, SDC Coordinator) and Licensed is lab process for residents of to include; obtaining PT/INR corresponding lab results, it levels, signs of coumading toxicity, drawing blood is, requisitions to contracted orting to nurse supervisor for obtain the sample as ordered results and labs that are	F 5	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	including when not d provider and that 2) to communicates inabilithe Charge Nurse for obtain blood sample provider if unable to Physician/Nurse Prawithin given paramet use of the PT/INR flot lab results, next lab ochanging coumading resident therapeutic results and missed late Physician/Nurse Prawithin strators, Direct Licensed Charge Nuturing orientation. On 2/7/22, the Intering Licensed Charge Nucurrent facility and according to process for residents include; obtaining PT	rawn by contracted lab the licensed nurse ity to obtain lab as ordered to ralternate interventions to and 3) reporting to medical obtain and 4) notifying the octitioner of PT/INR levels not ers and 5) education on the ow records for documenting draw date and current and/or orders to maintain each INR range and reporting all ab draws to the	F 5			
	toxicity, drawing blood requisitions to contral reporting to nurse su to obtain the sample lab results to the Phy Education also includicensed nurse to ensulted as ordered contracted lab provide nurse communicates ordered to the Charginterventions to obtain	adin toxicity, treatment for d samples for PT/INRs, cted lab provider and pervisor for alternate options as ordered and reporting all vician/Nurse Practitioner. ded 1) responsibility of the sure blood samples are including when not drawn by the rand that 2) the licensed inability to obtain lab as e Nurse for alternate n blood sample and 3) provider if unable to obtain				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		345128	B. WING		0.0	C 2/23/2022
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F 580	of PT/INR levels n 5) education on the records for current documenting lab recurrent and/or cha maintain each resi reporting results on Physician/Nurse Pagency licensed non 2/7/22 will not with The Director of Nuremployee list to tra This responsibility Director of Nursing and Risk on 2/7/22 work until education also be included distaff.	age 33 e Physician/Nurse Practitioner of within given parameters and e use of the PT/INR flow PT/INR parameters, esults, next lab draw date and nging coumadin orders to dent therapeutic INR range and utside of parameters to the ractitioner. Licensed facility and urses not receiving education work until education completed. rsing will utilize a master ack completion of education. was communicated to the g by the Director of Regulatory 2. Staff will not be allowed to on is completed. Education will uring orientation for newly hired	F	580		
	day resident lab is ensure PT/INR lab documented on the PT/INR flow record physician/nurse pr will complete a lab the lab binder on to on the lab log all o order will be transcelectronic medical order on the Medic (MAR). Licensed Medical record for orders. If PT/INR of Mondays, Wednes lab provider will oblicensed nurse is resure.	ordered to be drawn will as are obtained as ordered, and All results reported to the actitioner. The licensed nurse requisition, place requisition in the nursing unit and document rders for PT/INRs. The lab cribed into the resident record which will display new cation Administration Record Jurses will refer to electronic all new PT/INR physician orders are to be drawn on stays or Fridays, the contracted otain blood samples. The esponsible for obtaining on in the absence of the				

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345128	B. WING			02/	23/2022
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ACCORDIOS HE	EALIHAI SIAIES	VILLE		S	STATESVILLE, NC 28677		
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continurs orde notif impli reco resu level phys orde PT/II licen on th by n mee Educ (incli this: Lice rece educ utiliz of ec com Dire will r com orier On 2 Serv DON nurs durir are c withi lab c	se supervisor is usered, the Physicial ried, interventions emented and doord. The licensed alts will report all list not within give sician/nurse pracers as indicated. NR flow record was and many and the nursing management of the nursing decition was initiated to record of Nursing for the nursing education of the nursing education of the nursing education of the nursing education. This resumminated to the cord of Regulator not be allowed to pleted. Education that ion for newly allowed to plete of the nursing education of the nursing morning clinic obtained as order in given parameted draws are reported.	ler. If the licensed nurse or nable to obtain lab draw as an/Nurse Practitioner will be and/or new orders cumented in the medical nurse receiving PT/INR lab PT/INR results including n parameters to titioner and implement new The individual resident will be updated by the maintained in the lab binder flow records will be reviewed tent in clinical morning ingoing compliance. The individual resident will be updated by the maintained in the lab binder flow records will be reviewed tent in clinical morning ingoing compliance. The individual resident in clinical morning ingoing compliance. The individual resident in clinical morning in PT/INR lab process. The in PT/INR lab process. The in PT/INR lab process. The in PT/INR lab process is agency licensed nurses not on 2/7/22 will not work until in The Director of Nursing will oyee list to track completion sponsibility was and Risk on 2/7/22. Staff work until education is in will also be included during	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022		
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PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
Effective 2/7/2 Nursing will not on ensure corand notification practitioner is obtained and parameters. A weekly. Effective 2/7/2 of Nursing will implementation removal for the Alleged Date. A credible allest the facility on Resident #1's results, care pin-service trainingled nursing importance of testing and not completed as changes in a result outside individual result of 2/8/22 was 2. Resident #12/21/20 with schizophrenia person's abiliti	I day shation du 22, the anonitor in pliance on to the complete for PT/haudits w 2022, the labeled in the set of IJ Research and I set of IJ Research and I set of IJ Research and I set of IJ Research and III set of IJ Research and II set of IJ Re	aift charge nurse(s) will ring orientation. Administrator or Director of residents with PT/INR orders with obtaining, monitoring a Physician/Nurse reted for labs unable to be NR levels not within given rill be completed five times The Administrator and Director mately responsible to ensure is immediate jeopardy red noncompliance. The Administrator and Director mately responsible to ensure is immediate jeopardy red noncompliance. The Administrator and Director mately responsible to ensure in mately responsible to ensure in mately responsible to ensure red noncompliance. The Administrator and Director mately responsible to ensure in mately responsible to ensure in mately responsible to ensure in mately responsible to ensure red noncompliance. The Administrator and Director mately responsible to ensure in mately res	F 5	80				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 580	(MAR) for January 2 7P-7A shift, Resident medications and was which is associated of The following ordere administered during milligram (mg) daily hallucinations, Melat Ativan 0.5 mg twice Seroquel 25 mg twice Seroquel 25 mg twice A nurses note writter 1/6/21 effective 7:57 #14 didn't receive ar she was on the unit was not given to this not sent over nor was was transferred to unis no phone on unit was personal phone to castable report given to An interview on 02/0 #16 revealed she was and cared for her du Nurse #16 stated she COVID-19 isolation relaborated to say stated.	cation Administration Record 022 revealed on 1/5/22 on t #14 did not receive any is initialed to indicate a #9 with a linked nurses note. It is dementially defined to the shift: Depakote 125 for demential with onin 3 mg daily for insomnia, daily for anxiety, and is edaily for Schizophrenia. In by Nurse #16 and dated AM read in part: "Resident by medications on shift due to for 2 days and shift report nurse and medication was is this nurse told the resident with the medications there when this nurse uses her all no one answers resident is	FS	580	IENCY)			
	area because of isol explained she did no came on shift to make placed on the unit ar Resident #14 had be her ordered medicat	ation precautions. She treceive report when she te her aware Resident was ad later in the shift discovered ten transferred there without tions. Nurse #16 indicated Resident #14 because she						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 580	Continued From page		F 5	80		
	and there is no way t the facility to obtain n	to her ordered medications o access the main portion of nedications from the backup did not notify the provider were not provided.				
	Interim Director of Nu Administrator reveals orders and administe	ed staff to follow physician's or medications as indicated, cations were unable to be				
	Physician (MD) revea aware Resident #14 schedule medications time. The MD explair residents to receive r be notified if they wel medications. The MD	s on the night of 1/5/22 at the ned she expected all medications as ordered and re unable to provide also stated Resident #14 ations could have caused uch as hallucinations izophrenia and was				
	10/19/19 with diagno following a cerebral in	readmitted to the facility on ses that included hemiplegia nfarction (paralysis of an stroke), insomnia, and				
	(MAR) for January 20 7P-7A shift, Resident medications and was	cation Administration Record 022 revealed on 1/5/22 on 1 #15 did not receive any 2 initialed to indicate a #9 2 vith a linked nurses note.				

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				23/2022
NAME OF PI	ROVIDER OR SUPPLIER	0.0120		S	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022
ACCORDI	US HEALTH AT STATES	VILLE	520 VALLEY STREET STATESVILLE, NC 28677		20 VALLEY STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 580	administered during the for insomnia, Lorvasta prevention, Melatonin bedtime snack for we Keppra 500mg BID for A nurses note written 1/6/21 effective 7:56 at 15 didn't receive any because he was on the not given to this nurse sent over nor was this transferred to unit with explained there was resident #16 used he one answers resident oncoming nurse. " An interview on 02/04 #16 revealed she was and cared for him dur Nurse #16 stated she COVID-19 isolation unelaborated to say state unit when assigned to area because of isola explained she did not came on shift to make was placed on the undiscovered Resident there without her order #16 indicated she did because she did not medications and there main portion of the fafrom the backup stock.	d medications were not he shift: Ambien 5mg daily atin 40mg daily for stroke in 10mg daily for insomnia, a sight loss and diabetes, and or seizures disorder. by Nurse #16 and dated AM read in part: "Resident y medications on shift in e unit and shift report was a and medication was not is nurse told the resident was in no medications. She into phone on unit and when it is stable report given to 1/22 at 8:00 AM with Nurse is familiar with Resident #15 ining night shift on 1/5/22. It was assigned to work the init on that night and iff were unable to leave the or care for residents in that	F	580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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		345128	B. WING _			2/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIF 520 VALLEY STREET STATESVILLE, NC 28677	P CODE		
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F 580	Interim Director of Nu Administrator reveale orders and administer and in the event mediadministered, the proof The Administrator ack to the COVID unit we that unit and there was tock for that unit. The nurse should have co the facility to obtain a	/22 at 12:20 PM with the rsing (DON) and the d staff to follow physician's medications as indicated cations were unable to be wider was to be contacted. In the contacted staff assigned re not supposed to come off s not a backup medication to the main portion of	F	580			
F 583 SS=D	the facility to obtain any needed medications for administration. An interview on 02/9/22 at 5:30 PM with the Physician revealed she was not made aware Resident #15 had not received his schedule medications on the night of 1/5/22 at the time. The MD explained she expected all residents to receive medications as ordered and be notified if medications were unable to be provided. The MD also stated Resident #15 was placed at an increased risk of seizures and low blood sugar secondary to him missing his medication for epilepsy and his nighttime snack. Personal Privacy/Confidentiality of Records		F	583		3/25/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 583	§483.10(h)(2) The faresidents right to per right to privacy in his written, and electron the right to send and mail and other letters materials delivered to including those delivithan a postal service §483.10(h)(3) The reand confidential pers (i) The resident has to for personal and med provided at §483.70(federal or state laws (ii) The facility must a Office of the State Loto examine a resider administrative record law. This REQUIREMEN' by: Based on record reviewed when Resident who sustate of 3 resident reviewed when Resident #4, Fill #20 reported the detoverheard by staff more than the sustant for the findings included the state of the staff more resident who sustant for the sustant for the staff more resident who sustant for the findings included the staff more resident for the staff more resident	the facility to provide a resident. cility must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened of packages and other of the facility for the resident, ered through a means other of the facility for the resident and medical records. sident has a right to secure onal and medical records. The right to refuse the release ical records except as in (2) or other applicable allow representatives of the ong-Term Care Ombudsman at the medical, social, and is in accordance with State of its in accordance with State of its in the facility for 1 and for accidents (Resident #3) desident #19, and Resident allow in incident as embers.	F5	How corrective action will be accomplished for those residence; The facility failed to protect the resident #3 who sustained a facility. Staff will continue to resident privacy by discussing incidents/care issues in designursing room away from other those the facility will identify on the facility will identify on the facility will identify t	dents found to eficient he privacy of fall in the respect ng resident gnated er residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345128	B. WING _		l 0.	2/23/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O	•	POPEDE	
				520 VALLEY STREET			
ACCORD	US HEALTH AT STAT	ESVILLE		STATESVILLE, NC 28677			
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
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F 583	Continued From p	age 41	F 5	583			
		ange Minimum Data Set (MDS) dicated that Resident #3 was		having the potential to be a same deficient practice;	affected by the		
		and required total assistance					
	with transfers.			Effective 3/14/2022 the Dir			
	An observation on	nd interview with Resident #3		Nursing and/or designee wutilizes the room behind th			
		n 02/02/22 at 8:32 AM.		station to prevent other res			
		esting in bed and was alert. He		being affected by this prac			
		alled falling from the bed on		g p			
	12/22/21 and reca	alled that he had laid in the floor		Address what measures w	ill be put into		
		anyone came to help. Resident		place or systemic changes			
	#3 stated that he had to "use his reacher to turn			ensure that the deficient pr	ractice will not		
		staff could come in and help" by injury from the fall and stated		recur:			
		f finally came in to help, they		Effective 3/24/2022 Directo	or of Nursina		
		him off the floor and up to my		and/or designee educated	-		
		dent #3 denied being sprayed		and agency Certified Nurs			
	with any type of cl	eaner or disinfectant.		Medication Aides and Lice			
				ensuring residents informa			
		as readmitted to the facility on		discussed in a private area			
	10/14/21.			designated room behind the station.	ne nurses		
	Review of the gua	rterly Minimum Data Set (MDS)		Station.			
		dicated that Resident #19 was		Effective 3/24/2022 all Cer	rtified Nursina		
	cognitively intact.			Assistances, Medication A	•		
				License Nurses including A	Agency staff		
	Resident #19 was	interviewed on 02/02/22 at		before their first assignmen	nt, will be		
		he interview Resident #19		educated in orientation in p			
		ember right before Christmas		Director of Nursing and/or			
		nursing staff members at the		"ensuring residents information			
		king about Resident #3 falling oor for several hours before staff		discussed in a private area	1.		
		ident #19 stated that she had		Indicate how the facility pla	ans to monitor		
		king about Resident #3 being		its performance to make si			
		e and no one wanted to care for		solutions are sustained:			
		ed him with bleach or some					
	type of disinfectar			Administrator will make ob	servational		
				rounds of the nurse's static	•		
	b. Resident #4 wa	is admitted to the facility on		weeks to ensure residents	information is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			1	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 583	(MDS) dated 10/28/2 was cognitively intact Resident #4 was intered 12:19 PM. During the stated that a couple of overheard the nursing talking about Resident Resident #3 had falle would put him in his of himself. Then when the poured bleach and a laid in floor for a couphelped him. c. Resident #20 was in 109/02/17. Review of the annual dated 01/09/22 indicated on 109/22 indicated on 109/02/17. Resident #20 was intered as 112 PM. During the instated in December 2 and other resident all about Resident #3 wheard that no one was he had urinated on his sprayed him with bleat that it was a disinfect also overheard that Resident	ion Minimum Data Set 1 indicated that Resident #4 viewed on 02/02/22 at interview Resident #4 f months ago he had g staff on the back hall at #3. They stated that n out of bed because no one shair, and he had urinated on ne staff responded they disinfectant on him, and he alle of hours before anyone Minimum Data Set (MDS) ted that Resident #20 was erviewed on 02/02/22 at interview Resident #20 021 she had overheard staff over the building talking no had fallen out of bed. She inted to touch him because mself and so the staff ach but then the staff stated ant not bleach. Resident #20 iesident #3 had laid in the ours before assisted him. not recall which staff ard talking about the	F	583	discussed privately. Results of these audits will be reviewed monthly Quality Assurance Meeting X of for further problem resolution if needed Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345128	B. WING		02/23/2022	
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	,	
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F 583	interviewed on 02/02 confirmed that she we #3's fall that occurre stated later after the by the housekeeping been sprayed with a cleaner and they incomplete stated she reported did an investigation, vacation and did not investigation. Nurse #10 was inter PM. Nurse #10 confi Manager in the facili December when Review rumors going around sprayed with bleach stated that former Dhad an in-service with rumors that were cirk nurse #10 stated the residents would go of "gossip" she stated the Resident #19, and Fall in the smoking a had not specifically the fall but again stated that former Dhad and the smoking and had not specifically the fall but again stated that fall but again stated that fall but again stated that Resident #19. The Administrator we 3:40 PM. The Administrator was a stated that Resident was that Res	of Nursing (DON) #1 was 3/22 at 11:20 AM. DON #1 was made aware of Resident d in December 2021. She event she was made aware g staff that Resident #3 had a bleach or some type of juired if he was ok. DON #1 that to the Administrator who but she stated she left for a know what came of the viewed on 02/07/22 at 1:01 irmed that she was a Unit ity. She stated that in sident #3 fell there were do that Resident #3 had been or some type of cleaner. She ON #1 or the Administrator the the staff to clear up the culating around the facility. At she knew some of the bout to the smoking area and that maybe Resident #4, Resident #20 heard about the rea. Nurse #10 stated she heard any staff talking about the theard any staff talking about the theart any staff talking about a sistrator stated that she was #3 had a fall in December	F 58	3		
	with bleach or some	d that he had been sprayed type of cleaner. She stated esident #3, and he denied				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	/ILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677	1 02/	ZJIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	Administrator stated " overheard a conversa have a room behind t be used for report and	ny cleaner or bleach. The	F	583			
F 584 SS=B	CFR(s): 483.10(i)(1)-(§483.10(i) Safe Envir The resident has a rig	onment. ght to a safe, clean, elike environment, including iiving treatment and	F	584			3/25/22
	homelike environmen use his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall exthe protection of the roor theft. §483.10(i)(2) Housek services necessary to and comfortable intereight shall extend the protection of the roor theft.	clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident bes not pose a safety risk. exercise reasonable care for esident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 584	Continued From page	e 45	F 5	84		
	§483.10(i)(5) Adequa	ate and comfortable lighting				
	levels. Facilities initia 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by:	table and safe temperature illy certified after October 1, a temperature range of 71 to maintenance of comfortable is not met as evidenced ons, record review, and staff		How corrective action will be		
	of 2 resident dining a repair dry wall in resi Room #234, and Roo	failed to repair cabinetry in 1 reas, failed to paint and/or dent rooms (Room #134, om #229), failed to clean up oor (Room #116), failed to		accomplished for those resident have been affected by the defic practice; The facility failed to repair cabin	ient	
	remove a large bag of and failed to clean a	of soiled linen (Room #130), spill of feeding tube formula #102) for 2 of 4 hallways.		2 resident dining areas. Cabine repaired by 3/24/22.		
	The facility also failed that had a missing dr resident reviewed (R	d to repair a bedside table awer facing for 1 of 1 esident #2).		The facility failed to paint and/or wall in resident rooms #134, #2 #229. Dry wall in rooms 134, 23 were repaired and painted to make the second seco	34 and 34 and 229	
	The findings included	l:		wall color by 3/25/22.		
	facility was conducte The left wall of the di	f the main dining room of the d on 02/03/22 at 3:56 PM. ning room had a long row of n the wall and a lower set of		The facility failed to clean up a son the floor in room #116. Brief on 2/4/22.		
	cabinets that ran the that hung on the wall noted to be missing t cabinets. There had part of the missing ca	same length of the cabinets . The lower cabinets were he door facing of the lower been plywood nailed to cover abinets but part of the inside		The facility failed to remove a la soiled linen in room #130. Soile sent to laundry on 2/4/22 and flocleaned by housekeeping.	d linen oor	
	of the cabinets remai	ned visible and exposed.		The facility failed to clean a spill tube formula from the floor in ro		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			1	C 23/2022
NAME OF P	ROVIDER OR SUPPLIER	_ I	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	23/2022
					20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	SVILLE			TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From pag	ge 46	F t	584			
		e main dining room of the ed on 02/04/22 at 9:03 AM.			Floor stripped and waxed on 2/3/22.		
	The left wall of the d	ining room had a long row of			The facility failed to repair a bedside ta	ble	
	cabinets that hung o	on the wall and a lower set of			that had a missing drawer face in room		
	_	same length of the cabinets			#228B. Drawer face repaired on 2/4/22		
		II. The lower cabinets were					
	noted to be missing	the door facing of the lower			How the facility will identify other reside	ents	
	cabinets. There had	been plywood nailed to cover			having the potential to be affected by tl	ne	
		abinets but part of the inside ined visible and exposed.			same deficient practice;		
					On 3/14/22, the Maintenance Director		
	1b. An observation of	of Room #134 was made on			completed an observational inspection	of	
		I. On the long wall to the			resident rooms, dining areas, halls and		
		n was 2 large areas of white			resident common areas to identify		
		ed with dry wall puddy but			cabinetry/furnishings, dry wall and wall		
	had not been painte	d the same color as the rest			paint/coverings to identify any addition		
	of the room.				needed repairs. Repairs and additional		
					painting will occur on a schedule until a		
	02/04/22 at 9:23 AM	oom #134 was made on I. On the long wall to the			rooms have been painted and/or dry w	all.	
		n was 2 large areas of white			On 3/14/22, the Housekeeping Superv		
		ed with dry wall puddy but			completed observational rounds to ens	ure	
	·	d the same color as the rest			floors in resident rooms and resident		
	of the room.				common areas were clean and free of		
					spills and soiled linens or briefs. No		
		of Room #234 was made on I. On the long wall to the			additional concerns observed.		
		n were several areas of white			Address what measures will be put into)	
		ed with dry wall puddy but			place or systemic changes made to		
	-	d the same color as the rest			ensure that the deficient practice will n	ot	
	of the room.				recur:		
	02/04/22 at 9:26 AM entrance of the room	oom #234 was made on I. On the long wall to the n were several areas of white ed with dry wall puddy but			Effective 3/24/22 all staff received education by Administrator/Maintenand Director on reporting repairs into TELS that will automatically alert Maintenance		
		d the same color as the rest			Director of a work order generated. Ne		
	of the room.	u the same color as the lest			hired facility and agency staff will recei	-	
	or the foolit.				education during orientation.	v G	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C 23/2022	
NAME OF P	ROVIDER OR SUPPLIER	1 0.0.20	 		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022	
	101.52.1.011.001.1.2.2.1				220 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE			STATESVILLE, NC 28677			
					, T			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F 584	Continued From pag	e 47	F 5	584				
	1d. An observation o	f Room #239 was made on						
	02/03/22 at 4:33 PM.	. There were several large			Effective 3/24/22 resident rooms will be	•		
	areas of white that ha	ad been patched with dry			inspected during department head rou	าds		
	wall puddy but had n	ot been painted the same			to ensure floors are clean and free of			
	color as the rest of th	ne rom on both long walls of			spills; soiled briefs and linens are not o	'n		
	the resident room.				the floor and wall coverings and			
					furnishings are in good repair. Any			
		oom #239 was made on			concerns identified will be reported to			
		. There were several large			maintenance or housekeeping according	ngly		
		ad been patched with dry			and documented in TELS with areas			
	wall puddy but had not been painted the same color as the rest of the room on both long walls of				addressed to maintain a safe, clean, sanitary, and homelike environment.			
	the resident room.	le room on both long walls of			Monitoring for completion will also be			
	the resident room.				discussed during morning department			
	1e. On observation of	of Room #116 was made on			head meetings.			
	_	. In the bathroom there was a			g			
	soiled brief hanging f	from the handrail that was so			Indicate how the facility plans to monitor	or		
		and rested on the floor.			its performance to make sure that solutions are sustained:			
	On observation of Ro	oom #116 was made on			Solutions are sustained.			
	_	A. In the bathroom there was			Administrator or designee will observe	5		
		g form the handrail that was			resident rooms, hallways, dining rooms			
		ung and rested on the floor.			and resident common areas 2x weekly			
	,				weekly x 2 months, and monthly x 2	,		
	An interview was cor	nducted with Housekeeper #2			months to ensure floors are clean and			
	on 02/04/22 at 2:50 F	PM. Housekeeper #2 was			free of spills, soiled briefs and linens a	nd		
	observed coming out	t of Room #116 and getting			wall coverings and cabinetry/furnishing	S		
	ready to enter the ne	ext room on the hall.			are in good condition and repair. Any			
		s asked if she had cleaned			areas discovered will be addressed			
	•	was handing on the handrail			immediately.			
		replied, "I don't recall" and						
	⁻	way into the next room on the			Results of these audits will be reviewed			
	hallway.				Monthly Quality Assurance Meeting X			
	The Herrester C	N			for further problem resolution if needed	i.		
		Supervisor was unavailable			Administrator will review the results of			
	for interview on 02/04	4/22 at 3:30 PIVI.			weekly audits to ensure any issues identified are corrected.			
	1f An observation of	Poom #130 was made on			identified are corrected.			
		Room #130 was made on There was an extra-large			Completion date: 3/25/22			
	02/04/22 at 9.10 AW.	. There was an extra-large			Completion date: 3/25/22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 02/23/2022		
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, Z 520 VALLEY STREET STATESVILLE, NC 28677	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 584	was full of soiled line sheets, wash clothes An observation of Ro 02/04/22 at 12:28 PM clear trash bag lying was full of soiled line sheets, wash clothes An interview was cor on 02/04/22 at 2:50 F confirmed she was re Room #130 and indic cleaned that room. S recall" if there was a bathroom when she considered to the sheets.	in the bathroom floor that in that included towels, and bed pads. om #130 was made on the floor that in the bathroom floor that included towels, and bed pads.	F	584				
	for interview on 02/04/19. An observation of 02/03/22 at 4:01 PM. pole that had bottle of hanging from the pole tube pole and the floor noted to have dried by the same color as the was hanging from the An observation of Ro 02/04/22 at 9:06 AM. pole that had bottle of hanging from the pole tube pole and the floor noted to have dried by	f Room #102 was made on There was a feeding tube if tube feeding formula ie. The base of the feeding or surrounding the pole was brown liquid that appeared ie feeding tube formula that ie pole. In the was feeding tube if tube feeding formula ie. The base of the feeding or surrounding the pole was brown liquid that appeared ie feeding tube formula that						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345128	B. WING _				C 23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	stated that he has be since October 2021 a painting and repairing had a COVID outbreat that the 300 and 400 and repairs done but been done yet. The Mapproximately 4-5 roc October 2021 but add the dry wall mud on the since before he got to working on getting the The MS stated that he have the cabinets in the and was told no becathe was doing the best he had. The Administrator was 3:40 PM. The Administrator was to including weekends be housekeeping staff. The been disposed of by the Administrator stated the MS start painting and units that had not be with the COVID outbraround Christmas time the progress but added.	pervisor (MS) was 22 at 2:43 PM. The MS en working at the facility and had been working on grooms but when the facility at they stopped. He added hall have been repainted 100 and 200 halls had not and stated that he had done om that were empty since died that the rooms that have men have been that way to the facility, and we are men repaired and painted. The had asked previously to the dining room replaced use it was too expensive so the could with the supplies as interviewed on 02/07/22 at the strator stated that each the cleaned each day by a member of the The soiled brief should have	F	584			
		dmitted to the facility on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022		
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP 520 VALLEY STREET STATESVILLE, NC 28677	CODE	02/20/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE		
F 584	#2's was cognitively During an interview wat 3:10 PM an observed middle front panel frotable which was laying table. The Resident obeen laying on his been laying on	Minimum Data Set 1/24/21 indicated Resident intact. with Resident #2 on 02/02/22 vation was made of the om the drawer of his bedside into on top of the bedside explained that the panel had edside table for about two ious Activities Director had eer to have it fixed. AM an observation of the ed on the top of Resident with the Maintenance 12/04/22 at 12:45 PM he not have a work order to nel on Resident #2's bedside mediately address the plained that the staff were the TEL system, which was a by could request a work repair ff did not utilize the system at all. Inducted with the ting Director of Nursing on The Administrator explained the facility educated all staff corting needed repairs on the art of the facility's plan of last recertification survey. Intinued to explain that to	F	584				
	posted directions for	er on the staff, the facility the system at the nursing could also utilize an app on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(С
		345128	B. WING			02/	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		52	TREET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584		gardless, the Administrator should have been repaired		584 585			3/25/22
SS=D	grievances to the faci that hears grievances reprisal and without for reprisal. Such grievar respect to care and tr furnished as well as the furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The restacility must make processore grievances the accordance with this secondance with this secondance with this secondance with this grievance policy to error all grievances regal contained in this para provider must give a contained in this para provider must give a contained in postings in prominent facility of the right to fereight	ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination has been that which has not been for of staff and of other concerns regarding their LTC dident has the right to and the empt efforts by the facility to be resident may have, in paragraph. It was to make information ance or complaint available dility must establish a ensure the prompt resolution right of the grievance policy rievance policy must endividually or through the locations throughout the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \	TIPLE CONSTRUCTION ING	. ,	DATE SURVEY COMPLETED
		345128	B. WING			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE	•	STREET ADDRESS, CITY, STATE 520 VALLEY STREET STATESVILLE, NC 28677	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI) CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 585	of the grievance offican be filed, that is, address (mailing an number; a reasonal completing the reviet to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvemen Agency and State L program or protectic (ii) Identifying a Grieresponsible for over receiving and trackic conclusions; leading by the facility; main information associal example, the identitic grievances submitted written grievance decoordinating with stanecessary in light of (iii) As necessary, to prevent further poter ight while the alleginvestigated; (iv) Consistent with reporting all alleged abuse, including injund/or misappropria anyone furnishing sprovider, to the admas required by State (v) Ensuring that all include the date the	ously; the contact information cial with whom a grievance his or her name, business d email) and business phone ole expected time frame for ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, at Organization, State Survey cong-Term Care Ombudsman on and advocacy system; evance Official who is reseing the grievance process, and grievances through to their grany necessary investigations taining the confidentiality of all ted with grievances, for y of the resident for those and anonymously, issuing ecisions to the resident; and ate and federal agencies as a specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately violations involving neglect, curies of unknown source, ation of resident property, by ervices on behalf of the ninistrator of the provider; and	F	585		

NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) OPREFIX (EACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE COMPLETED ACTION SHOULD SHOULD BE COMPLETED ACTION SHOULD	_ ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	COMPLE	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED (EACH CORRECTIVE ACTION SHOULD BE COMPLETED ACTION SHOULD SH			345128	B. WING _		C 02/23	/2022		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION CONSTRUCTION SHOULD BE TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			VILLE	520 VALLEY STREET		1 02/20			
DEFICIENCY)	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE		
F 585 Continued From page 53 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (iv) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by; Based on record review and facility staff and resident interviews, the facility failed to address filed grievances for 1 of 1 resident reviewed for grievances (Resident #4). The Findings Included: Con 3/9/22, the Administrator (Grievance Coordinator) met with Resident #4 to identify any unresolved grievances. Grievance form completed and concerns resolved. A review of Resident #4's Admission Minimum Data Set Assessment dated 10/28/21 revealed Resident #4 to be cognitively intact with no psychosis, behaviors, or rejection of care. A review of facility provided grievances by Resident #4 to intentify any unresolved grievances. Grievance form completed and concerns resolved. A review of facility provided grievances by Resident #4 to intentify any unresolved grievances. A feview of facility provided grievances by Resident #4 to complete and concerns resolved. A feview of facility provided grievances by Resident #4 to complete and concerns resolved. A review of facility provided grievances by Resident #4 to complete and concerns resolved. A feview of facility provided	F 585	the steps taken to insummary of the pertiregarding the resider as to whether the griconfirmed, any corretaken by the facility and the date the writ (vi) Taking appropria accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or locatonfirms a violation frights within its area (vii) Maintaining evid result of all grievance 3 years from the issudecision. This REQUIREMENT by: Based on record reversident interviews, the filed grievances for 1 grievances (Resident The Findings Included Resident #4 was adra 10/26/21. A review of Resident Data Set Assessment Resident #4 to be copsychosis, behaviors.	vestigate the grievance, a nent findings or conclusions of some concerns(s), a statement evance was confirmed or not cive action taken or to be as a result of the grievance, the decision was issued; the corrective action in the law if the alleged violation is is confirmed by the facility is having jurisdiction, such as ency, Quality Improvement I law enforcement agency for any of these residents' for responsibility; and the ence demonstrating the ence of the grievance. This not met as evidenced the facility failed to address of 1 resident reviewed for the that is a state of the facility on the facility on the facility on the facility intact with notion, or rejection of care.	F 5	How corrective action will be accomplished for those residents have been affected by the deficier practice; On 3/9/22, the Administrator (Grie Coordinator) met with Resident #4 identify any unresolved grievances Grievance form completed and coresolved. How the facility will identify other rhaving the potential to be affected same deficient practice; Effective 3/14/22, the Social Work Administrator interviewed and reed	vance I to s. ncerns residents by the			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		l ,	c l	
		345128	B. WING				23/2022	
NAME OF PI	ROVIDER OR SUPPLIER	l	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02		
				5	20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		S	STATESVILLE, NC 28677			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 585	Continued From page	e 54	F	585				
					process of reporting grievances to the			
	_	vith Resident #4 on 02/02/22			Administrator (Grievance Coordinator)			
		rted he had filled out 8-10			placing grievance in mailbox located at			
	, •	admission to the facility in			Administrators door to ensure receipt of concerns for resolution.	Л		
		variety of issues including ff attitudes, and staff 'playing			concerns for resolution.			
		nallways". He stated each			Effective 3/14/22, the Administrator			
		nce out, he slid it under the			reviewed grievance log from 2/14/22			
		office door. He reported he			-3/14/22 to ensure timely resolution of	all		
		ollow-up from facility staff			filed grievances.			
		he went to the Administrator						
	to ask about the follow	w up. He reported when he			Effective 3/14/22, residents that are			
	questioned the Admir	nistrator about the lack of			cognitively impaired/Responsible party	will		
		ances, she reported she did			continue to be informed of the grievand	е		
	not know anything ab	out them.			process upon admission.			
	During an interview w	vith the Director of Nursing			Address what measures will be put into)		
		52 AM she reported she was			place or systemic changes made to			
		ance official while she was at			ensure that the deficient practice will no	ot		
	_	e Administrator would be the			recur:			
		evance reports. She stated			F 0/04/00 1			
		eived grievances under her			Effective 3/24/22 education provided b	У		
		id not remember receiving			Administrator to department heads on	:I. <i>i</i>		
		I. She also stated she			communicating all reported resident/fall grievances to the Grievance Coordinat			
		nt #4 and reported she was grievances he alleged to			(Administrator) and completing a	OI		
	,	d if the grievances would			grievance form and turning in immedia	telv		
		her door, she would have			to Administrator to ensure appropriate	СТУ		
	addressed them or pa				follow-up and resolution of concerns. T	he		
		eported she only dealt with			Administrator is the designated Grieval			
	grievances related to				Coordinator and will receive and ensur			
	- -				resolution of resident/family grievances			
	During an interview w	rith the Administrator on			Newly Hired department heads will			
	_	she reported she was			receive education upon hire.			
		ances filed by Resident #4						
		4 had filed grievances and			Indicate how the facility plans to monitor	or		
	-	e Director of Nursing's door,			its performance to make sure that			
		ded the grievances at the			solutions are sustained:			
	morning meetings the	ev have. The Administrator						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 02/23/2022		
NAME OF PE	ROVIDER OR SUPPLIER	0.0.20	1	SI	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022	
					20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES\	/ILLE		S	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		LD BE COMPLETIO		
F 585	her about the missing	e 55 emember him speaking to grievances and that she es to be addressed and	F	585	The Administrator or designee will audivia questionnaire 3 cognitively intact residents and the grievance log to ensignievances are received and resolved timely. Monitoring will occur 2 x/wk x 4 weeks them 1x/wk x 12 weeks. Results monitoring, with tracking and trending, be reported by Administrator to the Quantum Assurance Performance Improvement committee monthly and changes will be made to the plan as necessary to	ure s of will ality		
F 600 SS=E	CFR(s): 483.12(a)(1)	Neglect m Abuse, Neglect, and	F 6	500	maintain compliance. Completion date: 3/25/22		3/25/22	
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemi treat the resident's me §483.12(a) The facility	involuntary seclusion and ical restraint not required to edical symptoms.						
	physical abuse, corpo involuntary seclusion; This REQUIREMENT by: Based on record revi (NP), and Physician (neglected to provide of				How corrective action will be accomplished for those residents found have been affected by the deficient practice;	d to		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED		
		245400	D WING			l	c
		345128	B. WING _			02/	23/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET		
				S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	residents resided on Resident #15) and al snack for Resident # reviewed for neglect. Findings included: 1. Resident #14 was 12/21/20 with diagno schizophrenia (menta person's ability to thin and dementia with ha impairment with a pe heard, touched, taste wasn't there). A review of the Medic (MAR) for January 20 7P-7A shift, Resident medications and is in was associated with following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) daily following ordered me administered during the milligram (mg) and milligram (mg) and	e she did not know the her unit (Resident #14 and so failed to provide a nightly 15 for 2 of 2 residents admitted to the facility on ses that included al disorder that impairs a nk feel and behave clearly) allucinations (memory reeption of having seen, ed, or smelled something that cation Administration Record 122 revealed on 1/5/22 on at #14 did not receive any itialed to indicate a #9 which a linked nurses note. The dications were not the shift: Depakote 125 or dementia with onin 3 mg daily for insomnia, daily for anxiety, and the daily for Schizophrenia. The by Nurse #16 and dated AM read in part: "Resident y medications on shift due to or 2 days and shift report nurse and medication was as this nurse told the resident	F	600	Resident #14 and resident #15 did not suffer any adverse side effects as a resident medications not being administered timely on 1/5/22 and resident #15 also receiving bedtime snack. Resident #14 transferred off covid unit to well unit on 1/13/22 and Resident #15 transferred twell unit on 1/11/22 and medications continue to be available and administer as ordered. How the facility will identify other reside having the potential to be affected by the same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee reviewed residents with rooms changes from 2/14/22 – 3/14/22 to ensure medication were transferred with resident and available for administration and bedtime snack was provided if ordered by the physician. Resident medications were available and administered as ordered, including bedtime snacks. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 3/24/2022 Director of Nursing and/or designee educated current faciliand agency Licensed Nurses and Medication Aides (MA) on ensuring	not ored ents ne	
	is no phone on unit w personal phone to ca	it with no medications there hen this nurse uses her Il no one answers resident is			medications is transferred immediately appropriate medication cart when residents have a room change and ver	bal	
	stable report given to	oncoming nurse."			shift to shift report provided by ongoing		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	ZOIZUZZ
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ACCORDI	US HEALTH AT STATES	/ILLE			20 VALLEY STREET TATESVILLE, NC 28677		
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	An interview on 02/04 #16 revealed she was and cared for her duri Nurse #16 stated she COVID-19 isolation u elaborated to say staf unit when assigned to area because of isola explained she did not came on shift to make placed on the unit and Resident #14 had bee her ordered medicatio she did not medicate did not have access to and there is no way to the facility to obtain m stocked supply. 2. Resident #15 was 10/19/19 with diagnos following a cerebral in extremity following a se diabetes. A review of the Medic (MAR) for January 20 7P-7A shift, Resident medications and is ini was associated with a following ordered med administered during th for insomnia, Lorvasta prevention, Melatonin	e 57 e/22 at 8:00 AM with Nurse is familiar with Resident #14 ing night shift on 1/5/22. Was assigned to work the nit on that night and if were unable to leave the ocare for residents in that tion precautions. She receive report when she her aware Resident was idlater in the shift discovered en transferred there without ons. Nurse #16 indicated Resident #14 because she in her ordered medications of access the main portion of hedications from the backup in transferred there without ons. In the shift discovered en transferred medications of access the main portion of hedications from the backup in the shift included hemiplegian farction (paralysis of an instroke), insomnia, and in the dications were not he shift: Ambien 5mg daily atin 40mg daily for stroke in 10mg daily for insomnia, a ight loss and diabetes, and	TAG	600	and off going nurses. Education include rounding on residents on your assigned unit regularly including at start of shift. The licensed nurse and/or MA is responsible for transferring medications appropriate medication cart when reside room changes occur and continuing to administer medications and bedtime snacks timely as ordered by the physice Newly hired facility and agency license nurses and MAs will receive education during orientation and prior to first shift worked. Indicate how the facility plans to monitority its performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit residents with rooms changes to ensure medications were transferred we resident and available for administration and bedtime snack was provided if ordered by the physician. Monitoring will be completed weekly X weeks. Results of these audits will be reviewed at Quality Assurance Meeting monthly for further problem resolution in needed. Director of Nursing will review results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	ed d s to dent ian. d	DATE
	A nurses note written	by Nurse #16 and dated					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	RIPLE CONSTRUCTION NG	(X3	OMPLETED		
		345128	B. WING			C		
	ROVIDER OR SUPPLIER US HEALTH AT STATES		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		CODE	02/23/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 600	1/6/21 effective 7:56 #15 didn't receive ar because he was on not given to this nursent over nor was the transferred to unit wexplained there was Resident #16 used from answers resident oncoming nurse." An interview on 02/0 #16 revealed she was and cared for him do Nurse #16 stated she COVID-19 isolation elaborated to say strunit when assigned area because of isol explained she did not came on shift to make a placed on the undiscovered Resident there without her ord #16 indicated she did because she did not medications and the main portion of the from the backup stores.	AM read in part: "Resident by medications on shift the unit and shift report was see and medication was not a sis nurse told the resident was a sith no medications. She has no phone on unit and when her personal phone to call no and it is stable report given to the stable report when the stable report when she are the stable report when she are her aware Resident #15 and later in the shift the stable report given to the stable report given to the stable report given the stable report given to the stable report given the stable report given to the stabl	F	600				
	The Administrator act to the COVID unit w that unit and there w stock for that unit. T	er medications as indicated. cknowledged staff assigned ere not supposed to come off vas not a backup medication the Interim DON stated the come to the main portion of						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
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		345128	B. WING			02/	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		52	REET ADDRESS, CITY, STATE, ZIP CODE 0 VALLEY STREET IATESVILLE, NC 28677		
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F 636 SS=D	administration. An interview on 02/9/2 Physician revealed shall Resident #14 or Resident #14 or Resident schedule medical at the time. The MD eresidents to receive in MD also stated Resident medications could habehaviors such as haber schizophrenia and her medications as or revealed Resident #1 increased risk of seizz secondary to him misepilepsy and his night Comprehensive Asse CFR(s): 483.20(b)(1)(1)(1)(1)(1)(2)(1)(2)(3)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	22 at 5:30 PM with the he was not made aware dent #15 had not received ations on the night of 1/5/22 explained she expected all nedications as ordered. The lent #14 missing these we caused increase allucinations secondary to d was important she receive redered. The interview further 5 was placed at an ures and low blood sugar ures and low blood sugar ures and low blood sugar ures in the snack. It is sments & Timing (2)(i)(iii) seessment duct initially and periodically curate, standardized ment of each resident's ensive Assessment Instrument. In a comprehensive dent's needs, strengths, a preferences, using the instrument (RAI) specified sment must include at least demographic information		636			3/25/22
	(iii) Cognitive patterns						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02:20:202	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 636	(ix) Continence. (x) Disease diagnosis (xi) Dental and nutrition (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trighthe Minimum Data Se (xviii) Documentation assessment. The assinclude direct observation with the resident, as whicensed and nonlicer members on all shifts §483.20(b)(2) When the second of the s	or patterns. ell-being. hing and structural problems. and health conditions. conal status. ts and procedures. hing. of summary information hal assessment performed gered by the completion of et (MDS). of participation in seessment process must ation and communication well as communication with hised direct care staff	F 63	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	•	02/20/2022
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F 636	F 636 Continued From page 61		F 6	36		
	or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record rev facility failed complete Data Set assessment area assessments wi for 3 of 3 resident rev Resident #6, and Res The findings included 1. Resident #3 was re 12/07/21. Review of the signific Set (MDS) dated 12/2 completed on 02/01/2 time frame for complete MDS Nurse #1 was in 12:19 PM who stated suddenly left and their to train her on how to care area assessment that the former MDS Resident #3's MDS b former MDS nurse ha area assessments wh assessment late. MD	e every 12 months. Is not met as evidenced Is we and staff interview the e comprehensive Minimum es with the subsequent care thin the required time frame iewed (Resident #3, sident #7). Exact that the facility on Interviewed on 02/04/22 at that the former MDS nurse re was no one at the facility fully complete the MDS and ants. MDS Nurse #1 added nurse had completed ut was not aware that the and not completed the care nich made the entire S Nurse #1 indicated that		How corrective action will be accomplished for those resider have been affected by the defin practice; The facility failed to complete a Comprehensive Minimum Data assessment for resident #3, re and resident #7, within 14 days. Resident #3 was transmitted a accepted on 2/2/22. Resident #6 was transmitted a accepted on 2/7/22. Resident #7 Comprehensive a on 1/10/22 transmitted and accepted accepted and accepted and accepted ac	cient a Set sident #6 s. nd and ssessment cepted er residents sted by the sidents were nsure are	
	how to complete the 02/03/22 and she beg stated "they are already	orporation had shown her care area assessments on gan working on them but dy late." s interviewed on 02/07/22 at		completed within the required to All Comprehensive MDS Asset are current. Address what measures will be place or systemic changes ma	ssments e put into	
	3:40 PM. The Admini	s interviewed on 02/07/22 at strator stated she was not had late MDS assessment		ensure that the deficient practi- recur:		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			20,2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 636	until MDS Nurse #1 restated that she was nowas not properly train assessment but added proper training" so the completed timely. 2. Resident #6 was a 01/05/22. Review of the Admiss (MDS) dated 01/13/2 completed on 02/02/2 time frame for completed on 02/02/2 time frame for completed on 02/02/2 time frame for completed suddenly left and the to train her on how to care area assessment which in late. MDS Nurse #1 in their corporation had the care area assess began working on the already late." The Administrator was 3:40 PM. The Administrator was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train assessment but added in the stated that she was not properly train as the stated that she was not properly train as the stated that she was not properly train as the stated that she was not properly train as the stated that she was not properly train as the stated that	ecently told her. She also ot aware that MDS Nurse #1 ned to complete the entire and "we need to get her the e MDS assessment can be dmitted to the facility on sion Minimum Data Set 2 revealed that it was 22 which is after the 14-day	F	636	Effective 3/24/2022 Regional MDS Consultant educated MDS nurses on completing the comprehensive MDS within the required timeframe. The Nethired MDS staff will be educated during orientation. The Regional MDS Consul will provide back-up support to facility the ensure timely submission of all resident Comprehensive MDS Assessments. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit 5 residents comprehensive assessments weekly for 12 weeks to ensure comprehensive assessments are completed within the required timeframe. Results of these audits will be reviewed monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	tant to out or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 636	Continued From page	€ 63	F6	36		
	3. Resident #7 was a 07/28/17.	dmitted to the facility on				
	record revealed an a (MDS) assessment w Reference Date) of 0	#7's electronic medical nnual Minimum Data Set vith an ARD (Assessment 1/10/22. The MDS was not 14 day timeframe and had to the state agency.				
	Nurse #1 on 02/04/22 explained that the pre- left and there was no on how to fully compl assessments. The M corporate staff had sl	with the Minimum Data Set 2 at 12:20 PM the Nurse evious MDS Nurse suddenly one at the facility to train her ete the MDS and care area DS Nurse indicated that nown her how to complete ments on 02/03/22 and she a late assessments.				
F 641 SS=D	the Administrator and Administrator explain that the facility had la she did not know that properly trained to the MDS Nurse recently Administrator indicate provide the proper tra the MDS process cou Accuracy of Assessm	ed that the facility would aining to the MDS Nurse so ald be completed timely.	F 6	41		3/25/22
	resident's status.	of Assessments. It accurately reflect the is not met as evidenced				

1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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LE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	,	
UST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
In and facility staff and facility failed to accurately mum data set and discharge planning for d (Resident #4). Imitted to the facility on a that osteomyelitis, natic amputation of right traumatic amputation of Is admission Minimum ated 10/28/21 revealed tively intact with no ejection of care, or Resident #4 was coded and 144 pounds (lbs). MDS Nurse #2 on he verified she was the ted Resident #4's a Set Assessment. She ow what to say and that ment to the best of her the facility's previous 2/07/22 at 3:04 PM, she nches did "not seem I with a resident with e facility would have at it should not have been She stated she could not	F 6	How corrective action will be accomplished for those residents f have been affected by the deficien practice; The facility failed to accurately cod Admission Minimum Data Set for r #4. The facility modified resident #4 to discharge as "planned" on discharge as "planned" on discharge assessment on 10/28/2021 and retransmitted on 3/4/2022. The facility modified resident #4 to "height" on admission on 10/28/20 retransmitted on 3/4/2022. How the facility will identify other rehaving the potential to be affected same deficient practice; Effective 3/14/2022 Minimum Data Nurses reviewed 30 days of discharesidents to ensure accuracy of coplanned and/or unplanned. No addiconcerns identified. Effective 3/14/2022 Minimum Data Nurses reviewed current resident to ensure accuracy of coding. No additional concerns identified. Address what measures will be puplace or systemic changes made to ensure that the deficient practice were sident practice will be puplace or systemic changes made to ensure that the deficient practice will be puplaced.	de an resident reflect ge reflect 21 and residents by the residents residents reflect arge reflect arge reflect reflect arge reflect r	
		A SOLDING B. WING LE MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL PREFIX TAG 4 F 64 A, and facility staff and facility failed to accurately mum data set and discharge planning for d (Resident #4). Imitted to the facility on a that osteomyelitis, natic amputation of right traumatic amputation of 's admission Minimum ated 10/28/21 revealed tively intact with no ejection of care, or Resident #4 was coded and 144 pounds (lbs). IMDS Nurse #2 on the verified she was the ated Resident #4's as Set Assessment. She bow what to say and that trament to the best of her In the facility's previous 2/07/22 at 3:04 PM, she nches did "not seem d with a resident with the facility would have at it should not have been She stated she could not height was but was	## STREET ADDRESS, CITY, STATE, ZIP CODE \$20 VALLEY STREET STATESVILLE, NC 28677 ## STATESVILLE, NC 28677 ## PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD FREFIX TAG CROSS-REFERENCED TO THE APPR DEFICIENCY) ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice; ## How corrective action will be accomplished for those residents I have been affected by the deficien practice;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 641	b. A review of Resid Data Set Assessme Resident #4 to be of psychosis, behavior instances of wander as expecting to be of However, he was consomeone about the facility and returning in the community."	lent #4's admission Minimum nt dated 10/28/21 revealed ognitively intact with no es, rejection of care, or ring. Resident #4 was coded discharged to the community. Oded as not wanting to "talk to possibility of leaving the g to live and receive services Resident #4 was also coded as asked about returning to the	F€	641	Effective 3/24/2022 Regional MDS Consultant educated MDS nurses on coding MDS assessment accurately pe RAI guidelines. Newly hired MDS staff be educated during orientation by Regional MDS Consultant or designee coding MDS assessment accurately. Indicate how the facility plans to monite its performance to make sure that solutions are sustained: Administrator will audit 5 discharge assessments weekly to ensure dischar	will on or		
	at 12:17 PM, Reside expected to be adm he had. He reported made it clear he had discharge and live of did not remember be facility if he wanted his discharge plans or if he wanted to be assessments about stated, "why would I discharge to the cordid not want to spear	with Resident #4 on 02/02/22 ent #4 reported he had not itted the facility for as long as d when he was admitted he d wanted to eventually on his own. He reported he eing asked by anyone in the to speak to someone about and living in the community, e asked on future his discharge plans. He I tell them I wanted to mmunity and then tell them I			Administrator will audit 5 admission assessments weekly to ensure assessment for height are coded accurately. Results of these audits will be reviewer monthly in Quality Assurance Meeting further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022			
	02/04/22 at 10:09 A remembered very lit Resident #4's admis Assessment. She re	with MDS Nurse #2 on M, she reported she ttle about the completion of sion Minimum Data Set eported the discharge						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	<u> </u>	5212312022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641	Resident #4 because social worker at the tompleted. When as	complete but had to for the facility did not have a ime the assessment was sked why Resident #4 would	F 6	341		
	then state he did not about discharge plan discharging in the fut know what to tell you assessment] to the b answers he gave me coded Resident #4 a the community but no anyone about dischar	ture, she reported "I don't I, I completed [the lest of my ability and the ". When asked why she s expecting to discharge to out wanting to speak to rging to the community she I completed the assessment				
F 655	02/07/22 at 2:47 PM know why Resident at Data Set Assessment planning on discharge then as not wanting the discharging or be as future assessments.	with Director of Nursing #1 on she reported she did not #4's admission Minimum at was coded with him ing to the community and so speak to anyone about ked about discharge on The Director of Nursing um Data Set Assessments	F 6	555		3/25/22
SS=D	S483.21 Comprehen Planning \$483.21(a) (1) The faimplement a baseline that includes the insteller.	sive Person-Centered Care				J. LJI LL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _		02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 655	admission. (ii) Include the minir necessary to proper including, but not lin (A) Initial goals base (B) Physician orders (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recom §483.21(a)(2) The facomprehensive care plan if the com (i) Is developed with admission. (ii) Meets the required (b) of this section (e) this section). §483.21(a)(3) The resident and their resident and their resident and their resident and their resident in the baseline care limited to: (i) The initial goals	alan must- thin 48 hours of a resident's mum healthcare information rely care for a resident nited to- ed on admission orders. s. mendation, if applicable. acility may develop a e plan in place of the baseline prehensive care plan- hin 48 hours of the resident's ements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the expresentative with a summary plan that includes but is not of the resident. he resident's medications and	F6	55		
	administered by the on behalf of the faci (iv) Any updated info of the comprehension This REQUIREMEN by: Based on record refacility failed to dever	facility and personnel acting		How corrective action will be accomplished for those residents for have been affected by the deficient		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 02/23/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	2/23/2022	
				520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 655	Continued From page	e 68	F 65	55			
		ng status of the resident for		practice;			
		wed for smoking (Resident		,,			
	#6).	3 (The facility failed to develop a	baseline		
				care plan in the area of smoki			
	The findings included	i :		surgical wound care within 48	hours of		
				admission for resident #6.			
		nitted to the facility on					
		ses that included multiple		How the facility will identify oth			
	fractures to left lower	-		having the potential to be affect same deficient practice;	cted by the		
		ion assessment dated					
	•	eted by Nurse #4 indicated		Effective 3/14/2022, the Direct			
		multiple surgical incisions.		Nursing reviewed current resid			
		ssment did not address		admitted from 2/7/22 – 3/2/22			
	Resident #6's tobacc	o use.		baseline care plan was complete			
	The admission Minim	num Data Set (MD) dated		48 hours to address smoking wound care. All baseline care			
	01/13/22 revealed that	, ,		completed timely and accurate	•		
		required limited assistance		smoking status and wound ca	-		
		living. The MDS also		emoning status and wearing ou	10 110000.		
	_	nt #6 used tobacco and		Address what measures will b	e put into		
	required surgical wou			place or systemic changes ma			
				ensure that the deficient pract			
	Review of Resident #	#6's medical record on		recur:			
	02/02/22 revealed no	baseline care plan had					
	been developed upor	n admission.		Effective 3/24/2022 Director of			
				and/or designee educated cur			
		nterviewed on 02/04/22 at		and agency licensed nurses o			
		se #1 stated that she did not		completing baseline care plan	•		
		baseline care plans. She		admission to accurately reflect			
	stated that the admitting nurse was responsible for initiating the baseline care plan as well as			smoking status and wound ca			
		olan with the resident/family		within 48 hours of admission. admission nurse will be response			
		e Director of Nursing (DON)		initiating the baseline care pla			
		t would sign off on the		admission. Newly hired facility	•		
	baseline care plan.	a would sign on on the		licensed nurses will receive ed			
	Saconno dare piari.			during orientation and prior to			
	Nurse #10 was interv	viewed on 02/07/22 at 1:01		worked.	21 211		
		rmed that she was the Unit					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _				C
NAME OF F	PROVIDER OR SUPPLIER	0.0.25		ST	REET ADDRESS, CITY, STATE, ZIP CODE		02/23/2022
					0 VALLEY STREET		
ACCORD	IUS HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
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F 655	Continued From page	e 69	F 6	355			
r 000	Manager (UM) for Rewas able to complete had the time, but the admitting nurse and to come in and do their recently she has been and doing other thing review the recent admost recall being a paradmission. The Administrator and interviewed on 02/07 DON stated that base responsibility of the nadmission. She explagot admissions late in care plans were not at time it should be reported to be completed. The that as a second chead mission to ensure a were complete and the baseline care plan if the done so. The Administratif were educated in baseline care plan process of completing the baseline care plan process of completing the baseline care plan hours of admission. Nurse #4 was interviewed to the farshe had completed the skin assessment about his admission.	responsibility was really the hen the MDS Nurse would part. Nurse #10 stated that in working a medication cart is and had not had time to missions but stated she did it of Resident #6's Id interim DON were /22 at 3:40 PM. The interim beline care plans were the urses involved in the ained that at times the facility in the day and if the baseline able to be initiated at that borted to the oncoming nurse interim DON also stated ock, the UMs reviewed each all pieces of the admission ney were able to initiate the the admission nurse had not strator added that all agency in the last 4-5 months on the ocess and were aware of the grant of th	F 6	55	Indicate how the facility plans to monitits performance to make sure that solutions are sustained: Director of Nursing and/or designee waudit admissions to ensure resident smoking status and wound care needs are reflected on the baseline care plan within 48 hours of admission. Audits who be completed 2x/wk X 12 weeks. Results of these audits will be reviewed monthly Quality Assurance Meeting X for further problem resolution if needed Director of Nursing will review the result of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	ill s n will ed at 3 d.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APPLICATION CONTROL OF	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	
F 657 SS=D	CFR(s): 483.21(b)(2 §483.21(b) Comprer §483.21(b)(2) A combe- (i) Developed within the comprehensive a (ii) Prepared by an ir includes but is not lir (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent prather resident and the An explanation must medical record if the and their resident renot practicable for the resident's care plan. (F) Other appropriate disciplines as deternor as requested by the (iii) Reviewed and reteam after each assection comprehensive and assessments. This REQUIREMEN by: Based on record revision the areas of anticoreviewed for Couma	prehensive Care Plans aprehensive care plan must 7 days after completion of assessment. Anterdisciplinary team, that mited to aysician. Be with responsibility for the d and nutrition services staff. Acticable, the participation of resident's representative(s). Be included in a resident's participation of the resident presentative is determined be development of the e staff or professionals in a staff or professionals in a single by the interdisciplinary resident. Arised by the interdisciplinary resident are sident. Arised by the interdisciplinary resident. Arised by the interdisciplinary resident.	F	How corrective action will be accomplished for those residents have been affected by the deficie practice; Resident #1 comprehensive care revised on 2/7/2022 by the licens for use of anticoagulant medications.	ent e plan sed nurse	3/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C	
NAME OF D		343120	B. WING _	CTREET ADDRESS CITY STATE 7ID CO	•	2/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
ACCORDI	US HEALTH AT STAT	ESVILLE		520 VALLEY STREET			
				STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From p	age 71	F 6	57			
	10/21/21 with a red diagnoses that inc and acute embolis	s admitted to the facility on admission dated 12/16/21 with luded atrial fibrillation (A Fib) m and thrombosis of vein (DVT) of the lower		Resident #2 comprehensive revised on 2/7/2022 by the lifter care of pressure ulcer. How the facility will identify of	icensed nurse		
	extremity.	control and lewer		having the potential to be affi same deficient practice;			
	A care plan initiated on 11/22/21 included the use of Lovenox and Coumadin although Lovenox was discontinued on 12/9/21 with interventions dated 11/22/21 that included monitor for anticoagulant side effects every shift. A physicin's order dated 12/9/21 indicated Lovenox was discontinued.			Effective 3/18/2022 Minimur (MDS) and/or licensed nurse reviewed current residents comprehensive care plans for with anticoagulants and presto ensure accuracy. All revisional during audit.	e designee or residents ssure wounds		
	12/25/21 revealed received 6 of 7 day	Im Data Set (MDS) dated Resident #1 intact and ys of anticoagulants. he MDS Nurse Coordinator on		Address what measures will place or systemic changes r ensure that the deficient pra recur:	made to ctice will not		
	2/7/22 at 11:07 AM indicated she only started developing care plans approximately a month ago. She stated the care plan should include have been updated when the Lovenox was discontinued, and interventions should have been added to include monitoring for adverse effects from Coumadin therapy. An interview with the Interim Director of Nursing (DON) and the Administrator on 2/8/22 at 12:21			Effective 3/24/2022 Regional Consultant educated the ME updating comprehensive car residents with anticoagulant pressure wounds to reflect care needs. Newly hired MD receive education during orient MDS nurse will review new porders daily and make revision resident care plans to reflect	OS nurse on re plans for s and changes and OS nurses will entation. The physician ions to		
	modified as neederesident. For a res The DON and Adnanticoagulant care adverse effects su	re plans to be followed and ad for individualization to each ident on anticoagulant therapy, ninistrator expects plans to include monitoring for ch as bleeding or bruising, all d as ordered, and the medical		anticoagulant use and/or prewounds. Indicate how the facility planits performance to make sursolutions are sustained:	ns to monitor		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED	
		345128	B. WING		0	C 2/23/2022	
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	<u> </u>	02/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	2. Resident #2 was a 02/02/21. A review of Resident 05/26/21 revealed he ulcer development w to the left gluteal fold mobility and incontinincluded utilizing the prevention and treat weekly skin assessnincontinence care af episode. Resident #3 his current stage 4 p 01/27/22. A review of Resident revealed a Wound Conote dated 06/17/21 pressure ulcer to the resolved. The quarterly Minimulassessment dated 1 was cognitively intactulcers but had no prothe MDS assessment A review of a change dated 01/27/22 revealed of 1/27/22 revealed of 1/27/	aware of all results promptly. admitted to the facility on a #2's care plan dated	F 657		nsive ure eviewed at ting X 3 needed. ie results		
	note dated 02/03/22	nd Care Physician's progress revealed Resident #2 had a er on his right buttock that					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C 23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	, 02.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660 SS=D	An interview was comon 02/08/22 at 11:50 explained that she be #2's stage 4 pressure Physician's orders for MDS Nurse continued have updated Reside but she was overwhethe MDS Coordinator has been trying to do herself. On 02/07/22 at 3:40 Fthe Administrator and acknowledged the last recently left the comp was too overwhelming Administrator indicate corporate support for facility would get cause the MDS's and care published published Discharge Planning FCFR(s): 483.21(c)(1) (1) §483.21(c)(1) Dischart facility must deverted effective discharge plon the resident's disconference in the manifold of the process must be considered must be	x 1.4 cm with heavy serous recrosis. ducted with MDS Nurse #1 AM. The MDS Nurse reame aware of Resident relater when she read the relater the pressure ulcer. The did to explain that she should not #2's care plan on that day limed with her duties due to had recently quit and she all the MDS process by PM during an interview with Director of Nursing they st MDS Coordinator had reany and the MDS process g for one MDS person. The read that she would request the MDS Nurse, and the gold up with the backlog of plans. Process (i)-(ix) rge Planning Process related to the p		657			3/25/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02/20/202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 660	identify changes that discharge plan. The oupdated, as needed, (iii) Involve the interd by §483.21(b)(2)(ii), ideveloping the discharge plan and the resident's or person(s) capacity ar required care, as par discharge needs. (v) Involve the reside representative in the discharge plan and ir resident representative (vi) Address the resident representative in the discharge plan and ir resident representative (vi) Address the resident regarding returning to (A) If the resident ind to the community, the referrals to local contappropriate entities in (B) Facilities must up comprehensive care appropriate, in respo from referrals to local appropriate entities. (C) If discharge to the to not be feasible, the made the determinat (viii) For residents where the discharge is the contact of the contact o	d and result in the charge plan for each -evaluation of residents to require modification of the discharge plan must be to reflect these changes. isciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support do capability to perform to fit the identification of the identification of the inform the resident and we of the final plan. dent's goals of care and s. resident has been asked a receiving information to the community. icates an interest in returning to facility must document any fact agencies or other made for this purpose. Indate a resident's plan and discharge plan, as the information received it contact agencies or other the community is determined to the community is determined to the community is determined to community is determined to facility must document who	F 66		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 660	provider by using dat limited to SNF, HHA, patient assessment of measures, and data of the data is available. The post-acute care is assessment data, data on resource use the resident's goals of preferences. (ix) Document, compon the resident's nee record, the evaluation needs and discharge evaluation must be discharge plan to fact to avoid unnecessary discharge or transfer This REQUIREMENT by: Based on record reviewing resident interviews, the discharge planning pwishing to discharge #4) for 1 of 1 resident planning. The Findings Include Resident #4 was admito/26/21.	ts and their resident lecting a post-acute care a that includes, but is not IRF, or LTCH standardized lata, data on quality on resource use to the extent The facility must ensure that tandardized patient ta on quality measures, and is relevant and applicable to of care and treatment lete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident ncorporated into the illitate its implementation and or delays in the resident's is not met as evidenced iew and facility staff and the facility failed to have a process in place for a resident to the community (Resident to the community (Resident to the community (Resident to the facility on initted to the facility on	Fe	How corrective action will be accomplished for those residel have been affected by the defipractice; The facility failed to have a displanning process in place for reconstruction on 3/9/22, the Social Worker of discharge planning assessment Resident #4 to ensure discharge place.	cient charge esident #4. completed a nt for	
	Data Set Assessmen	#4's Admission Minimum t dated 10/28/21 revealed nitively intact. Resident #4		How the facility will identify oth having the potential to be affect		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345128	B. WING			
NAME OF DE	ROVIDER OR SUPPLIER	0.0.20		STREET ADDRESS, CITY, STATE, ZIP CODE	02/23/2022	
NAIVIE OF FI	NOVIDER OR SUFFLIER					
ACCORDI	US HEALTH AT STATES\	/ILLE		520 VALLEY STREET		
				STATESVILLE, NC 28677		
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F 660	Continued From page	e 76	F 66	0		
	was coded as indepe	ndent with bed mobility,		same deficient practice;		
		on and off the unit, dressing,		, ,		
		g. Resident #4 required		Effective 3/18/2022 the Social Work	er	
		g and personal hygiene.		reviewed current residents to ensure		
	Resident #4 was code			discharge plan is in place. Residents		
	discharged to the con	. •		without a documented plan had a		
	3	······································		discharge planning assessment		
	A review of Resident	#4's care plan dated		completed in the electronic medical		
		care plan area for discharge		record.		
	or discharge planning					
				Address what measures will be put i	nto	
	A review of Resident	#4's electronic progress		place or systemic changes made to		
	notes, scanned docur	· · · · · · · · · · · · · · · · · · ·		ensure that the deficient practice wil	l not	
		d no documentation from		recur:		
	any staff member reg	arding Resident #4's				
	discharge planning or	his plan to remain in the		Effective 3/24/2022 Administrator		
	facility long term.			provided education to the Social Wo	rker	
				on completing discharge planning fo	r	
	During an interview w	rith Resident #4 on 02/02/22		short term and long-term residents a	and	
	at 12:17 PM, he repor	rted he was admitted to the		documenting in the electronic medic	al	
	facility from the hospi	tal for treatment of wounds		record. Newly hired MDS staff will be	e e	
	to his body. He repor	ted it was his understanding		educated during orientation.		
	that he would only be	in the facility long enough to				
		nent and ensure his wounds		The Social Worker will complete a		
		e reported he told the facility,		discharge planning assessment upo		
		ne spoke with, he would like		admission for residents to ensure pr	oper	
		unity upon completion of his		planning for return to community.		
	antibiotics but had no					
	conversations with an			Indicate how the facility plans to mo	nitor	
	discharge planning pr	ocess.		its performance to make sure that		
				solutions are sustained:		
		erview with Resident #4 on				
		, he stated he had spoken		Administrator will audit admissions t		
		ordinator about wanting to		ensure discharge plans are in place		
		community around the end		weekly x 12 weeks.		
		He stated the Admissions				
		she could assist him with a		Results of these audits will be review		
		cility which he declined as d to be at home in the		monthly Quality Assurance Meeting for further problem resolution if need		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		LETED
		345128	B. WING _			02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
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F 660	he spoke to the Admidischarge planning is social worker employ admission. During an interview on 02/03/22 at 9:15 in just started the previous started the previous started she was or his discharge plan worked on 5-6 discharge plan worked on 5-6 discharge or in process for Residual of the original of	n a nursing facility. He stated issions Coordinator about his recause there was not a yed at the facility during his with the Social Worker (SW) AM, she reported she had ous Wednesday, 01/26/22. not familiar with Resident #4 is. She reported she had arges since she started, and discharge planning in place	F	660	Director of Nursing will review the result of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	lts	
	discharged to the co stated when a reside a care plan meeting soon after the admis	mmunity." The Administrator ent was admitted to the facility should be scheduled for sion and discharge planning with a discharge care plan					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION (X3) DATE SURVEY COMPLETED			
		345128	B. WING			С	
NAME OF PI	ROVIDER OR SUPPLIER	343120	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022	
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 660	home. The Administr know if there had bee place for Resident #4 not any discharge pla sure the facility got st for Resident #4. She had been without a fumonths up until 1/26/2 the SW duties, includ were divided up amore She reported she did Resident #4 was experimental facility and that she we plan to be in place for admission they had in home. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily is services to maintain of personal and oral hydromatical facility and family memoral facility and family memoral facility and family memoral facility for the services do no servation staff, and family memoral family memoral facility for the facility for the facility for the findings included the facility for the findings included the findings in find	ator reported she did not an any discharge planning in but reported if there were ns in place, she would make arted on discharge planning explained that the facility all time SW for around 3 22 and that during that time ing discharge planning, and the administrative team. Not know the time frame exceed to be admitted to the rould expect a discharge or residents who stated upon antentions of discharging for Dependent Residents The property of the received the receives the necessary good nutrition, grooming, and giene; The is not met as evidenced in some receives the facility antinence care when dent (Resident #3, Resident ident #10, Resident #11) and wer activities (Resident #2, sident #12) for 8 of 8 activities of daily living.		How corrective action will be accomplished for those residents fou have been affected by the deficient practice: Resident #2, resident #7 resident #11 list updated for bathing type and frequency preference and residents continue to receive showers per plan care Incontinence care for resident #3, resid	task of	3/25/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _		_	C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STA 520 VALLEY STREET STATESVILLE, NC 2867		T OEI ESI ESE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		
F 677	hypertension, bilaters and others. Review of a care plate part; Resident #3 has self-care deficit relate and bilateral lower expoal read; Resident acurrent level of activities review date. The interest review date. The interest required extensive members with toileting review of the signification of the significant o	ses that included diabetes, all lower limb amputations, an revised on 07/01/21 read in an activity of daily living and to a history of dementia attremity amputations. The 3 will maintain/improve ties of daily living through the avventions included: Resident assistance of 2 staffing. Cant change Minimum Data 15/21 indicated that Resident tact and required total ing. The MDS also indicted a frequently incontinent of and exhibited no behaviors or any the assessment reference atton and interview were 22 at 7:06 AM to 8:42 AM. At 2's call light was noted to be dent #3 was heard from the ed some help in here, I need ous staff members were up by during the continuous AM Nurse #10 was observed as room and turn off his call other staff had entered and he was continued to be any requesting to be changed. #3 again turned his call light	F6	#5, resident #9, resident #11 will continue to maintain incontinue. How the facility will having the potential same deficient prace. Effective 3/14/2022 and/or designee conquestionnaire with continent resident incontinent resident incontinence care in Cognitively impaired were monitored by it to ensure briefs are and not being left so concerns identified. reviewed in Electron (EMR) and updates plan, task list and M schedule to reflect in bath type and frequivalent that the deficiency: Effective 3/24/2022 Nursing and/or desicurrent facility and a Nursing Assistants of Nurses providing shincontinence care for per preference and	identify other reside to be affected by the stice: , Director of Nursing impleted and audit victognitively intact its to ensure its to ensure its dincontinent resider rounding observations being changed time oiled. No additional Bathing report in Medical Record is made to resident cath affect of the president preference in the president preference in the Director of the president president president president president of the Director of the president	ents le lia	
	in his bed, he had op	dent #3 was observed resting ened his brief and stated changed. Resident #3 was		Education included updating Master Sh bathing task list upo		th	

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345128	B. WING			02/	23/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
A C C O D D I	HO HEALTH AT CTATES	2/11/5		52	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		S	TATESVILLE, NC 28677		
(X4) ID	I .	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 677	Continued From pag	e 80	F	677			
		es and was also noted to			changes and the CNA providing care a	ıs	
		e. Resident #3 stated, "if I			scheduled and notifying licensed nurse		
	-	n my clothes don't get wet"			refusals and providing incontinence ca		
		n so long to come in and			by rounding every two hours and as		
		e hours between changes. At			needed for incontinent residents. The		
	8:42 AM Nurse Aide	(NA) #7 was observed to			licensed nurse will be responsible for		
	enter Resident #3's r	oom carrying his breakfast			maintaining shower schedules and		
	tray. When NA #7 en	tered the room and Resident			updates and the CNA will provide care		
	#3 stated "I need to I	oe changed I have been			and report refusals to the licensed nur		
		half for help." NA #7 took the			responsible for resident care for follow	•	
	-	his room and proceeded			Resident showers will be monitored fo	r	
		3's room to clean him up. NA			completion by the DON and/or Unit		
	1 ***	ent #3 often had on 2 briefs			Coordinator daily for compliance. The		
		mon occurrence" and			licensed nurse will monitor incontinend	e	
	·	dent #3 onto his side to wash			care compliance by routine rounding		
		t #3 was noted to have dried			observations throughout shift. Newly		
		which required NA #7 to			hired facility and agency licensed nurs CNAs and Unit Coordinators will receive		
		nove the dried feces. The was intact and slightly red			education during orientation and prior		
		to scrub the area to get			working.	10	
	_	up. Once Resident #3 was			working.		
		aced one new brief on him			Effective 3/24/2022 the Director of		
	· · · · · · · · · · · · · · · · · · ·	ced Resident #3 in his			Nursing and/or designee will educate		
		noving her gloves and			current facility and agency Certified		
		he brought Resident #3 his			Nursing Assistants, licensed nurses or	1	
	breakfast tray so he	•			providing incontinence care when		
					identified or requested prior to taking		
	Nurse #10 was interv	viewed on 02/02/22 at 5:45			meal tray into the room.		
	PM. Nurse #10 confi	rmed that she had turned off			-		
	Resident #3 call light	earlier that morning but			Indicate how the facility plans to monit	or	
	stated she had let the	e NA know that he needed			its performance to make sure that		
		ld not recall which NA she			solutions are sustained:		
	·	ed she let the direct care staff					
	on the hall know that	Resident #3 was requesting			The DON and/or designee will monitor		
	care.				dependent residents to ensure resider		
					are receiving showers and incontinent	е	
		was conducted with NA #7			care to meet needs. Monitoring will be		
		AM. NA #7 stated that on			completed via observational rounds ar		
	02/02/22 she was lat	e to work and did not report			review of shower records in the EMR 3	3X	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B WING	B. WING		C 02/23/2022	
		345126	B. WING _			02/	23/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/II I F		52	20 VALLEY STREET		
AGGGRE	OO HEAEIN AI OIAIEO			Sī	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 81	F 6	677			
	to duty until 7:50 AM	and was never told by Nurse			weekly then weekly for 8 weeks.		
		needed to be changed. NA					
	#7 indicated that she	had no idea Resident #3			Results of these audits will be reviewed	d at	
		she carried his breakfast			monthly Quality Assurance Meeting X		
	_	ice she knew he needed to			for further problem resolution if needed		
		ed she did provide care to			Director of Nursing will review the resu	lts	
		up to eat his breakfast. NA			of weekly audits to ensure any issues		
		s the only NA on the front and all of her residents only			identified are corrected.		
		care twice during her 8-hour			Completion date: 3/25/2022		
	shift "because that wa	_			Completion date. 3/20/2022		
	(DON) were interview. The DON stated that their checks of the resindividual needs and were then we can ensured are met in a time. Administrator stated to turned off without provesident and that whe it is the expectation the soon as possible. 2. Resident #9 was reconstructed to the control of the control	establish what their needs sure that their incontinence nelier fashion. The hat no call light should be					
	part; Resident #9 has self-care deficit relate The goal read; Reside level of function in act						
	Review of the annual	Minimum Data Set (MDS)					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, Z 520 VALLEY STREET STATESVILLE, NC 28677	ZIP CODE	, 02:20:2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 677	cognitively intact and rejection of care duriperiod. The MDS als was always inconting required extensive a A continuous observed to turn his He stated that he was breakfast but when he told him he would have breakfast. Resident had been picked up Nurse Aide (NA) #7 changed and was to soon as she could. A entered Resident #9 needed incontinence entered Resident #9 incontinence care. No Resident #9 to a state the soiled brief that was very wet and he to have dried feces or required NA #7 scrul clean. Resident #9 sthe end of her shift a her to put 2 briefs or while before he got of want to ruin his cloth. A follow up interview on 02/03/22 at 10:46 02/02/22 she was late to duty until 7:50 AM	aled that Resident #9 was a had no behaviors or ng the assessment reference to indicated that Resident #9 ent of bowel and bladder and ssistance with toileting. ation and interview were dent #9 on 02/02/22 from M. Resident #9 was call light on for assistance. It is wet and soiled since before the asked to be changed, they have to wait until after #9 stated that after the trays around 9:00 AM he told that he needed to be do she would get to him as at 10:35 AM Nurse #16 is room and was told that he e care. At 10:45 AM NA #7 is room to provide IA #7 was observed to assist anding position and removed was soiled with feces and havy. Resident #9 was noted on his buttocks which to the area to ensure he was tated to NA #7 that before it 3:00 PM he would like for a him because it would be a changed again and did not	F	577			

C		A. BUILDING	IDENTIFICATION NUMBER:	F CORRECTION	AND PLAN OF
02/23/2022		B. WING	345128		
•	REET ADDRESS, CITY, STATE, ZIP CODE VALLEY STREET ATESVILLE, NC 28677		/ILLE	PROVIDER OR SUPPLIER	
ION SHOULD BE COMPLETION THE APPROPRIATE DATE	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ID PREFIX TAG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENC	(X4) ID PREFIX TAG
		F 677	d as soon as breakfast as provided as requested. NA is the only NA on the front and had to pick up the pen began providing care to first time she was able to as at 10:45 AM. She stated, I could do." She added that y requested to have 2 briefs cause it would be a while diagain and doesn't want to 7 stated that if Resident #9 is on then she put 2 on him. Interim Director of Nursing and on 02/07/22 at 3:40 PM. The facility had to increase sident and look at the establish what their needs insure that their incontinence timelier fashion. The hat when a resident the expectation that the care has possible. The facility on sees that included sequelae incident, dementia, and a revised on 08/01/21 read in the revised on 08/01/21 rea	changed and was told over, care would be p #7 stated that she wa 200 unit on 02/02/22 breakfast trays and the get to Resident #9 wa "I was doing the best Resident #9 frequent and he said it was be before he got change ruin his clothes. NA # asked to have 2 briefs. The Administrator and (DON) were interview. The DON stated that their checks of the resindividual needs and were then we could eneeds were met in a standard trequested care it is the provided as soon a 3. Resident #10 was 03/01/05 with diagnos of cerebrovascular acothers. Review of a care plar part, Resident #10 ha incontinence related to	F 677
			the facility had to increase sident and look at the establish what their needs nsure that their incontinence timelier fashion. The hat when a resident se expectation that the care as possible. Treadmitted to the facility on ses that included sequelae ecident, dementia, and a revised on 08/01/21 read in ad bowel and bladder to dementia and impaired	The DON stated that their checks of the reindividual needs and were then we could eneeds were met in a fadministrator stated to requested care it is the provided as soon and 3. Resident #10 was 03/01/05 with diagnos of cerebrovascular acothers. Review of a care plar part, Resident #10 had incontinence related to mobility. The goal readers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION	,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		0	C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATI	ESVILLE		STREET ADDRESS, CITY, STATE, ZIF 520 VALLEY STREET STATESVILLE, NC 28677	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 677	dated 01/09/22 rev cognitively intact at with toileting. The I Resident #10 was bowel and bladder rejection of care duperiod. A continuous obsect conducted with Re AM to 8:15 AM. At Resident #10's call observed going in Resident #10's root stated that she needs was dark to know wilight on. She stated woke up and could turned the call light entered Resident #10 turned the hallway. At 7:3 stated she needed the hallway. At 7:3 stated she needed better turn my light AM Nurse #11 was #10's room and cheavily soiled with trash can made a I Nurse #11 was interest AM. Nurse #11 cor incontinent care to light was on but stand been on. Nurse	terly Minimum Data Set (MDS) ealed that Resident #10 was nd required limited assistance MDS further revealed that occasionally incontinent of and had no behaviors or uring the assessment reference evation and interview were sident #10 on 02/02/22 at 7:06 7:06 AM it was noted that light was on. Nurse #11 was and out of room just past m. At 7:26 AM Resident #10 eded to be changed, she stated the clock on the wall because it what time she turned the call d she had been asleep and tell that she was wet and e on. At 7:29 AM Nurse #10 e10's room and turned the call the room and continued down of AM Resident #10 again to be changed, "I guess I back on" and she did. At 8:15 observed to enter Resident ange her brief. The brief was urine and when thrown into the	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	 	02/23/2022	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From pag	e 85	F 6	77			
	that left them in a bir night and into the mo	aff that did not show up and ad. He added that during the brning they were not able to ntinence checks but "we do					
	PM. Nurse #10 confi Resident #10's call li stated she had let the care. Nurse #10 cou	viewed on 02/02/22 at 5:45 rmed that she had turned off ght earlier that morning but e NA know that she needed ld not recall which NA she ed she let the direct care staff : Resident #10 was					
	(DON) were interview. The DON stated that their checks of the reindividual needs and were then we can enneeds are met in a ti. Administrator stated turned off without proresident and that who	d Interim Director of Nursing wed on 02/07/22 at 3:40 PM. In the facility had to increase esident and look at the establish what their needs issure that their incontinence melier fashion. The that no call light should be oviding the need of the en a resident requested care hat the care be provided as					
	08/21/20 and recentl						
	part; Resident #11 haself-care deficit relate pulmonary disease a	n revised on 06/29/21 read in as an activity of daily living ed to chronic obstructive and others. The goal read; intain current level of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER	/ILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 677	review date. The inter #11 requires extensive members for toilet us. Review of a Medicare (MDS) dated 02/02/2 #11 was cognitively in assistance with toiletic revealed that Resider incontinent of bowel a behaviors or rejection the assessment refer. Review of a nurses in AM read in part, reside sleeping. Police were resident stating that is hours to be changed, she would find her Not get changed. The not Resident #11 was into AM. Resident #11 states turned her call ligicall phone) and then talked to them for a work with her family Residestayed on and no one assist her. She stated PM when she turned the phone with her fallight was still on, and family member told Resident #11 stated to member continued to member continued to	f daily living through the eventions included: Resident e assistance of 2 staff e. 2 5-day Minimum Data Set 2 indicated that Resident etact and required extensive eng. The MDS further ent #11 was always and bladder and no of care was noted during	F	677			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022		
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02/20/2022		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 677	was going to call the wellness check. Reshung up with her fan 11:00 PM so the fam police. Resident #11 11:00 PM the staff cathey were assigned building and apparent the building where Rishown up for work. That been in to assist that they were there stated that when the soaking wet all the will would be the staff membrassisting her the polistick around. Nurse #8 was intervial. Nurse #8 was intervial. Nurse #8 was intervial. Nurse #18 was assigned indicated that her far because Resident # some help for 3.5 hours was interview. Attempts to speak to unsuccessful.	family member decided she local police department for a ident #11 stated that she nily member a little before stated that shortly after ame in and explained that to the other side of the ntly the staff for the side of desident #11 resided had not help apologized that no one at Resident #11 and stated to assist her. Resident #11 staff changed her, she was way to the pad on the bed and ders were in the room did showed up but did not help and the stated she was when the police showed up to #11. Nurse #8 stated that gined to Resident #11 and nily had called the police in the room to get had been trying to get nurs.	F 67	77			
	but stated that arour were asked to go an	o take care of Resident #11 ad 12:30 AM she and NA #1 d check on the other side of there was staff that had not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP 520 VALLEY STREET STATESVILLE, NC 28677	CODE	02/20/2022	
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		*	CTION SHOULD BE THE APPROPRIAT	
F 677	the unit where Reside was on and so were of been on awhile." She needed to be change waiting on someone to NA #3 stated that Resexaggerated things be no idea how long Reson assistance. She six very wet and had a six brief. NA #3 confirme and heavy and as way while they were assist showed up but by the care with Resident #1 she went on to answer on and assist those report her assigned location. Attempts to speak to 02/04/22 were unsucced. Resident #11's family on 02/04/22 at 12:00 the previous night she with Resident #11 and turned her call light of 11:00 PM no one from assist her. After being the family stated they got no answer, so the with Resident #11 and wellness check. The	ed that when they went to ent #11 resided her call light others that "had probably stated that Resident #11 d and stated she had been to help her for several hours. Sident #11 did at times that the stated she honestly had sident #11 had been waiting stated that Resident #11 was small amount of feces in her did that her brief was very wet as her pad. NA #3 stated that ting Resident #11 the police time, they had completed the other lights that were sesidents before returning to s.	F	677			
	not heard anything el	number but stated she had se from them. iewed on 02/04/22 at 3:15					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022		
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/23/2022		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 677	Continued From pag	ge 89	F 67	7			
	night shift on 02/03/2 5 NAs but in fact the explained around 10 couple of the staff m schedule had not she assignments had go change at 7:00 PM. discovered that the s work they attempted	irmed that she worked the 22 and they thought they had y did not. Nurse #19 1:00 PM we discovered that a embers that were on the own up for their shift so those ne uncovered since the shift Nurse #19 stated when they staff had not shown up for to call the management staff is so they did the best they					
	(DON) were interview. The DON stated that their checks of the reindividual needs and were then we could needs were met in a Administrator stated.	nd Interim Director of Nursing wed on 02/07/22 at 3:40 PM. It the facility had to increase esident and look at the destablish what their needs ensure that their incontinence timelier fashion. The that when a resident the expectation that the care as possible.					
		admitted to the facility on oses that included diabetes					
	03/30/21 revealed the deficit performance in goal for Resident #2 level of function activattained by providing or shower cannot be A review of Resident	t #2's care plan dated the Resident had a self-care related to paraplegia. The to improve in his current vities of daily living would be g sponge bath when full bath totolerated. t #2's quarterly Minimum Data tent dated 11/24/21 revealed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION B	COMPLETED		
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 677	Continued From pa	ge 90 intact and required extensive	F 67	77		
	assistance of one p and bathing. The M	erson for personal hygiene DS also indicated the itinent of bowel and had no				
	ADL record for Janu 2022 revealed the F receive showers on evenings. There we	nt #2's (activities of daily living) uary 1 through February 2, Resident was scheduled to Monday and Thursday ere no showers documented his assigned shower days or timeframe.				
	with Resident #2 or Resident explained his showers on Mor but he had not had The Resident continuould inquire about there was not enoughowers and the besponge him off. The wash himself off at	interview were conducted to 2/02/22 at 3:10 PM. The that he was supposed to get anday and Thursday evenings, a shower since October 2021. The thin that when he this shower, he was told that the ghin help to give him his est they could do was to be Resident stated he could the sink, but it was not like shower. The Resident's hair of and stiff.				
	conducted with Nur with Resident #2 or 01/17/22, Thursday 01/24/22. The NA e vaccine mandates t and now, they are e that he has never g	D PM an interview was se Aide (NA) #12 who worked in Thursday 01/13/22, Monday 01/20/22 and Monday explained that before the the facility was short staffed even shorter. The NA stated iven the Resident a shower. D AM an interview was see Aide (NA) #3 who worked				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	·	OLI EGI EGE
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	shift. The NA explair remember the last ti shower. She continuous able to conscheduled for the evenot have enough he on 02/08/22 at 9:55 acknowledged that son Thursday 01/27/2 never given Resider on 02/08/22 at 10:2 confirmed she worked Monday 01/31/22 ar was short staffed, at could do because of stated she could not showered Resident while. Nurse Aide #11 work Monday 01/03/22 evening she worked at the facility interviewed. The Surveyor was u aide worked with Refore 01/06/22 evening she worked at the facility interviewed.	Monday 01/10/22 evening ned that she could not me she gave Resident #2 a ned to explain that they were complete all the showers rening shift because they do up to complete the tasks. AM Nurse Aide (NA) #13 she worked with Resident #2 22. The NA stated she has not #2 a shower. O AM Nurse Aide (NA) #14 end with Resident #2 on and explained that the facility and she had to do the she is being short staffed. The NA is remember the last time she #2 but that it had been a seed with Resident #2 on rening shift but no longer and unable to be unable to identify which nurse esident #2 on Thursday ifft.	F	DEFICIENCY)		
	Interim Director of N 3:40 PM they both re aware that the resid were not being given the facility would ree and adjust the amou	with the Administrator and ursing (DON) on 02/07/22 at emarked that they were not ents' scheduled showers in. The DON explained that evaluate the staffing needs ant of staff needed to provide idents. The Administrator and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _	B. WING			C 02/23/2022	
	ROVIDER OR SUPPLIER	VILLE		52	TREET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET TATESVILLE, NC 28677	1 02		
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 677	Continued From page	e 92	F	377				
	DON stated it was un go months without a	acceptable for a resident to shower.						
	6. Resident #5 was a 04/14/16 with diagnosthypertension.	dmitted to the facility on ses that included						
	limited mobility. The government level of care winterventions of externed mobility and externed for toileting and persodated 08/10/21 reveal bladder and bowel du. The goal that he wou breakdown related to would be attained by included place call ligincontinent care after	had a self care elated to hemiplegia and goal that he would maintain would be attained by utilizing usive assistance of one for ensive assist of two persons onal hygiene. A care plan led he was incontinent of ue to decreased sensation. Id remain free of skin incontinence and brief use utilizing interventions that ht within reach, provide						
	assessment dated 10 was cognitively intact assistance of one per extensive assist of two personal hygiene. The	Minimum Data Set (MDS) 24/21 revealed Resident #5 and required extensive rson for bed mobility and ro persons for toileting and e MDS also indicated the nent of bladder and bowel s of rejection of care.						
	movement and urine							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	, 32	20,2022	
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 677	hours and the last tine early morning before The Resident had an On 02/04/22 at 12:18 Nurse Aide #9 who with the shift and reporte be changed. The NA briefs which were so and urine and provide During an interview with 02/04/22 at 12:45 AN was assigned to Resident needed every two hours because the Resident needed every two hours becaused and explained that it expectation for the aid the incontinent reside provide the other dain not enough staff to p stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the amount of the continent #7 was a stated she was work provide the continent #7 was a stated she was work provide the continent #7 was a stated she was work provide the continent #7 was a stated she was work provide the she was work provide the continent #7 was a stated she was work provide the continent #7 was a stated she was work provide the continent #7 was a stated she was work provide the she	ked and changed every two he he was changed was third shift left for the day. Hodor of urine incontinence. B PM the Surveyor located was assigned to Resident #5 d the Resident's request to changed the Resident's filed with bowel movement ed incontinent care. With Nurse Aide #9 on M the NA confirmed that she ident #5 that day and that to be checked and changed ause he was incontinent of The NA verified that she had ged Resident #5 that shift was an unrealistic des to check and change ents every two hours and by tasks because there was rovide the care. The NA ing as fast as she could to of care the residents needed. Idmitted to the facility on ses that included diabetes	F 6	,			
	#7 had a self care per his diagnoses and de The goal to maintain function would be att	03/31/21 revealed Resident erformance deficit related to ecreased range of motion. current activities of living ained by requiring extensive aff for bathing/showering needed.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	,
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 677		n Data Set (MDS) 1/09/22 revealed Resident #7	F 67	7	
	rejection of care. The limited assistance to	t and had no behaviors of MDS indicated he required transfer for bathing and was ent of bladder and bowel.			
	the Resident was scl showers on Monday ADL record for Janua no showers docume	#7's ADL record revealed neduled to receive his and Thursday evenings. The ary 2022 revealed there were need for Resident #7 on his ays or any day in January			
	explained that he had since November 202 explain that he was son Monday and Thur asked about his show	n and interview with 3/22 at 2:50 PM the Resident d not received a shower 1. The Resident continued to supposed to get his showers saday evenings but when he wers the staff would respond e Resident had an odor			
	AM with Nurse Aide to work with Residen The NA stated she h	nducted on 02/05/22 at 10:40 (NA) #15 who was scheduled t #7 on Thursday 01/20/22. as never worked with e she has never given him a			
	#16 on 02/05/22 at 1 informed that she was Resident #7 on Mono The NA explained the Resident #7 a shower	nducted with Nurse Aide (NA) 2:20 PM. The NA was as scheduled to work with day 01/24/22 second shift. at she had never given but that a shower team to give showers when there			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING	B. WING		C 02/23/2022	
	NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE			5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677	1 02/	23/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	#12 on 02/05/22 at 1: he worked with Resid Thursday 01/13/22 at second shift and expl given Resident #7 a s the Resident was eve on second shift. An interview was con #4 on 02/07/22 at 3:2 that he worked with F 01/06/22 second shift never given Resident usually have people s The NA continued to not enough staff sche they do not give them they could do to prov residents. An interview was con #3 on 02/08/22 at 8:1 was scheduled to wo Monday 01/10/22 and give showers on seco enough staff schedule On 02/08/22 at 10:20 conducted with Nurse scheduled to work wi 01/31/22 second shift could only remember shower one time and	ducted with Nurse Aide (NA) 00 PM. The NA confirmed lent #7 on Monday 01/03/22, and Thursday 01/27/22 ained that he has never shower and did not know if an scheduled for a shower ducted with Nurse Aide (NA) 5 PM. The NA confirmed lesident #7 on Thursday and explained that she has #7 a shower because they scheduled to give showers. explain that when there was aduled to give showers then a showers because it was all ide the routine care for the ducted with Nurse Aide (NA) 5 AM the NA confirmed she rk with Resident #7 on d explained that they do not and shift unless they have	F	677			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	32/20/202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From pag	ge 96	F 6	577			
	Interim Director of N 3:40 PM they both re aware that the reside were not being giver the facility would ree and adjust the amout the needs of the residence of	admitted to the facility on oses that included diabetes obstructive pulmonary					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022		
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 677	An interview was co AM with Nurse Aide to work with Reside first shift. The NA e enough staff scheduled assign someone to continued to explain anyone scheduled impossible for the him residents and gives reason the scheduling given. On 02/07/22 at 12: conducted with Nurconfirmed that he will saturday 01/08/22. In the showers and saturday 01/08/22. The Surveyor was the showers. The Surveyor was the shower that the will saturday 01/29. Attempts were made who was scheduled 01/13/22 and Thurs #18 who was scheduled 01/13/24 and	inducted on 02/03/22 at 11:20 (NA) #9 who was scheduled int #12 on Thursday 01/27/22 explained that when they have used for the shift, they will give the showers. The NA in that if they did not have to give showers that it was shall staff to provide care to the showers as well and for that each showers could not be 10 PM an interview was see Aide (NA) #17 who worked with Resident #12 on The NA explained that he has esident #12 and that there was am scheduled to give the unable to identify the nurse with Resident #12 on Saturday 101/06/22, Saturday 01/15/22	F 67	7			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _				C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	, ,	
ACCORDI	US HEALTH AT STATES	/ILLE			0 VALLEY STREET FATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677		e 98 It of staff needed to provide Ients. The Administrator and	F	677			
		acceptable for a resident to					
F 684 SS=E	Quality of Care		F	584			3/25/22
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with professor plan, and the resident resident residents receive accordance with professor plan, and the resident re	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered sidents' choices. is not met as evidenced ons, record review, resident, e facility failed to follow reatment to a venous stasis alled to follow physician a diabetic foot ulcer alled to follow physician surgical wounds (Resident			How corrective action will be accomplished for those residents found have been affected by the deficient practice: Treatment for resident #7 venous statisfulcer was provided on 3/3/2022 and will continue to be provided as ordered by	s II	
	Resident #7 was an 07/28/17 with diagnost failure. The recent quarterly I assessment dated 10	dmitted to the facility on ses that included heart Minimum Data Set (MDS) /10/21 revealed Resident #7 and had no behaviors of MDS also indicated enous ulcers.			physician. Treatment for resident #18 diabetic foo ulcer was provided on 3/5/2022 and will continue to be provided as ordered by a physician. The facility failed to follow physician order treatment of surgical wounds for resident #6. Resident discharged on 2/8/2022.	t II the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		c	
		345128	B. WING			l	23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	LOILULL
				52	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 99	F	684			
	revealed an order dat	ted 01/11/22 to cleanse the			How the facility will identify other reside	ents	
	right lower leg venous	s ulcer with wound cleanser,			having the potential to be affected by the	ne	
	apply Xeroform gauze	e, wrap with Kerlix then			same deficient practice:		
	cover with coban onc	e a day on the day shift.					
					Effective 3/14/2022, Director of Nursing	3	
	A review of Resident				and/or designee reviewed current		
		d (TAR) for February 2022			residents receiving treatments to ensur	е	
		nt had not been signed out			treatments are done according to		
	for on 02/02/22 and 0	02/03/22.			physicians' orders. No additional conce were identified.	erns	
	A review of the staffin	ng assignment for 02/02/22			Address what measures will be put into)	
	day shift revealed Me				place or systemic changes made to		
	assigned to Resident	#7.			ensure that the deficient practice will no recur:	ot	
	An observation and ir	nterview were conducted					
	with Resident #7 on 0	02/03/22 at 2:55 PM. The			Effective 3/24/2022 the Director of		
	Resident explained the	nat he was supposed to have			Nursing and/or designee will educate t	ne	
		d on his right lower leg every			current facility and agency Licensed		
	1 -	the dressing was changed			Nurses on following physicians orders	for	
		22). An observation of the			residents with wound treatments and		
	dressing on the Resid				documenting completion on the Treatm		
	_	y was intact with a coban			Administration Record (TAR) as ordere		
	wrap and was undate	ed.			The licensed nurse will be responsible		
	Di	::Al- NA- di4: A: (NAA) #0			completing wound treatments as order		
	l	vith Medication Aide (MA) #2			and documenting on the TAR. License		
		PM the MA explained that			nurses that oversee Medication Aide w be alerted on the TAR. The facility will	Ш	
	so the treatment nurs	of the residents' treatments			monitor for wound treatment completio	2	
		the treatments if they had a			per the TAR compliance report during	1	
		duled that day. The MA			morning clinical meetings. Newly hired		
	continued to explain t				facility and agency licensed nurses will		
	treatment nurse sche				receive education during orientation ar		
		to her which was Nurse #20			prior to working.		
	_	ponsible for doing the			, ,		
	treatments.				Indicate how the facility plans to monito	or	
					its performance to make sure that		
	On 02/04/22 at 10:20	AM an interview was			solutions are sustained:		
	conducted with Nurse	e #20 who explained that she					
		ng change for Resident #7			The DON and/or designee will monitor		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	on 02/02/22 because management team b not accept the response medication aide's treshe did not remind make report it to the ortreatments were not on the accept it to the ortreatments were not on the accept it to the ortreatments were not on the accept it to the ortreatments were not on the accept in the accept in the dressing had not accept in the dressing had not accept in the	e she had informed the efore that day that she would insibility for doing a atments. The Nurse stated inanagement of that nor did incoming shift that the done. ervation were conducted 02/04/22 at 1:30 PM. The sing on the Resident's right The Resident explained that been changed since and the dressing should be as assignment for 02/03/22 as assigned to Resident #7. Inducted with Nurse #2 on who admitted that he did not change on Resident #7 on ings were chaotic on the halling other things and time got Nurse stated he should have into the night shift to do the got to. With the Administrator and ursing (DON) on 02/07/22 at leed that they were aware that then the system in the facility currently interest will be responsible for the	F	684	residents with treatment orders to ensutreatments completed and documented ordered 3 x weekly x 4 weeks, then weekly for 8 weeks. Results of these audits will be reviewed monthly Quality Assurance Meeting X for further problem resolution if needed Director of Nursing will review the result of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	d at 3	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 684	mellitus. The recent quarterly assessment dated 1 #18 was cognitively of rejection of care. Resident #18 had a A review of Resident dated 01/23/22 reveleft heel with wound apply betadine and cover with ABD padevery day shift. A review of Resident Administration Recorevealed the treatmeter on 02/02/22. A review of the staffi day shift revealed Massigned to Resident During an interview Resident #18 on 02/Resident explained to did not get changed ordered to be changed.	Minimum Data Set (MDS) 2/22/21 revealed Resident intact and had no behaviors The MDS also indicated diabetic foot ulcer. It #18's Physician orders aled an order to cleanse the cleanser, gently pat dry and double silver alginate then and wrap with kerlix daily on It #18's Treatment It (TAR) for February 2022 In had not been signed out Ing assignment for 02/02/22 Ind assignment for 02/02/22	F	584				
	Physician assessed the dressing was ap During an interview on 02/03/22 at 4:05 she could not do any so the treatment nur	his wound that morning and plied after the assessment. with Medication Aide (MA) #2 PM the MA explained that y of the residents' treatments						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED		
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	ROVIDER OR SUPPLIER	ESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/23/2022		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 684	continued to explait treatment nurse so working the hall ne would have been retreatments. On 02/04/22 at 10: conducted with Nurdid not do the dres on 02/02/22 becau management team not accept the respredication aide's to she did not remind she report it to the treatments were not accept the wound Management did not have a designation of 3:40 PM they explait the Wound Managemeded some attered did not have a designation of the wound Managemed (WCN) but that it was full time WCN that wound Managemed 3. Resident #6 was 01/05/22 with diagraph and fill accetabulum, non-demetatarsal bone, as	heduled that day. The MA In that if there was not a heduled then the nurse at to her which was Nurse #20 esponsible for doing the 20 AM an interview was ree #20 who explained that she sing change for Resident #18 se she had informed the before that day that she would consibility for doing a reatments. The Nurse stated management of that nor did concoming shift that the of done. With the Administrator and Nursing (DON) on 02/07/22 at ained that they were aware that ement system in the facility attion and the facility currently gnated Wound Care Nurse as a priority on their list to hire at will be responsible for the not process. Admitted to the facility on noses that included fracture of oula, fracture of left isplaced fracture of second	F 68				
	(MDS) dated 01/13 was cognitively into assistance with act	/22 revealed that Resident #6 act and required limited ivities of daily living. The MDS at Resident #6 had a surgical					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022		
	NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 684	revealed the following cleanse surgical sit cleaner, apply skin dressing daily. Cleanse surgical we cleaner and apply skin dressing daily. Review of the treating cleaner and apply skin dressing daily.	an order dated 01/22/22 ng: te left lateral calf with wound prep and cover with dry ound to left knee with wound prep and cover with dry ound to right knee with wound prep and cover with dry ound to left calf with wound prep and cover with dry ound to left hip with wound prep and cover with dry ound to left hip with wound which prep and cover with dry ound to left hip with wound which prep and cover with dry ment record dated 01/01/22 evealed no treatment orders	F 68				
		ment record dated 02/01/22 evealed no treatment order for e.					
	with Resident #6 or Resident #6 stated vehicle while riding fractures and surgion	interview were conducted n 02/02/22 at 11:49 AM. that he was hit by a motor his scooter and had multiple cal sites from his stay in the that his doctor had prescribed					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			1	23/2022
	ROVIDER OR SUPPLIER	VILLE	1	5	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 021	23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	the staff did not compound dressings on them who but had not had any is stated he would wash when he bathed but rapplied as ordered by were observed to be sutures, some had stalower leg were dry and begun to grow over the surgical incisions had of the incisions had of the incisions had a infection. Review of a orthoped 02/04/22 indicated the evaluated following stated was discussed and slike the evaluated following stated was frequently and stated frequently and stated was familiar with record and the had no surgical work was familiar with Resincisions with sutures was familiar with Resincisions with sutures was familiar with Resincisions wet broaders to the surgical	f his surgical incisions and blete them. He stated he had hen he came to the facility in place since then. He had he he sutures and incision ho dressings had been whis doctor. The incisions dry and scaly some had aples. The staples to the left individual dressing on them and none had resident #6 had been had he staples. None of the had dressing on them and none may redness or signs of his follow up note dated hat Resident #6 had been hard with Resident #6. The harged home on 02/08/22. The staples had been had he skin had he staples had been had he staples had been hard with Resident #6. The harged home on 02/08/22 had she cared for Resident #6 he had no daily wound care, to pull up the electronic had again confirm that Resident hound care orders. The had had she was one of the building. She stated that she had he doctor but was not able to get had a she was not able to but was not able to but was not able to had had he doctor but was not able to	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _		C 02/23	3/2022	
	ROVIDER OR SUPPLIER	/ILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/23/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 684	stated that each hall r wound care because wound nurse. She ex not had wound care r and they continued to wound care nurse. Sh #6's orders were enter medical record they st treatment record for of She was unable to ex entered but did not ap		F 6	84			
F 686 SS=J	S483.25(b) (1) Pressure S483.25(b) (1) Pressure Based on the compressional standard pressure ulcers and culcers unless the individemonstrates that the (ii) A resident with professional standard pressure ulcers and culcers unless the individemonstrates that the (ii) A resident with pressure ulcers are the individemonstrates that the pressure ulcers are the individent with professional start promote healing, previous ulcers from deverthis REQUIREMENT by:	event/Heal Pressure Ulcer (i)(ii) rity re ulcers. hensive assessment of a nust ensure that- is care, consistent with sof practice, to prevent loes not develop pressure vidual's clinical condition between unavoidable; and essure ulcers receives and services, consistent adards of practice, to vent infection and prevent loping. The is not met as evidenced in, record reviews, staff, visician and Physician	F 6	How corrective action will be accomplished for those residents have been affected by the deficient	s found to	3/25/22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C
NAME OF D		343120	B: Willo		TREET ADDRESS CITY STATE ZID CODE	02/	23/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET		
				S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 106	F 6	886			
		I services to maintain skin			practice;		
		t with a history of skin			practice,		
	breakdown. Resident				The facility failed to prevent and identif	v a	
		ling a foul odor and was			pressure ulcer Resident #2 who was a		
		e IV pressure ulcer (the			risk for pressure ulcers.	•	
		come very deep and as the					
		e or bone may be visible,			On 2/3/22, the Wound Physician		
	making infection a str	ong possibility if not cared			evaluated Resident #2 right buttock		
	for) on his right buttoo	ck. The facility also failed to			pressure ulcer. Wound staged as a Sta	age	
	·	er treatments for 2 of 3			4 wound with heavy serous exudate ar		
	residents (Resident #	•			100% necrotic. Scalpel debridement w		
	reviewed for pressure	e ulcers.			completed on the wound and new orde		
					implemented. Resident #2 will continue		
		began on 01/27/22 when the			receive wound care to heal and prever	ıt	
	_	ige IV pressure ulcer on			further skin breakdown. Care plan		
		when the facility provided			updated by MDS Coordinator.		
	and implemented an				How the facility will identify other reside		
	_	te jeopardy removal. The			having the potential to be affected by the	те	
	-	of compliance at a lower			same deficient practice;		
		level D (no actual harm with			December of the state of the st		
	-	than minimal harm that is			Because all residents are at risk for	_	
		dy) due to examples 1.b. nonitoring systems put into			pressure ulcers when skin changes are not reported and interventions	;	
		lated to pressure ulcers.			implemented to prevent breakdown, th	_	
	place are effective re-	lated to pressure dicers.			following plan has been devised:		
	The finding included:				lollowing plan has been devised.		
	The initiality included.				Effective 2/7/22, the licensed nurses a	nd	
	1a. Resident #2 was	admitted to the facility on			charge nurses completed head-to-toes		
		ses that included diabetes			assessments on 100% current facility		
	mellitus, acute transv	erse myelitis in			residents to identify residents with skin		
	demyelinating diseas	e of the central nervous			breakdown. Residents identified with		
		ia. The Resident had a			changes in skin condition were reporte		
		ulcer on the left gluteal fold			the physician and/or nurse practitioner	-	
	that was healed 06/1	7/21.			the licensed nurse and follow-up order		
					obtained as appropriate. The Minimum		
		#2's Braden Assessment			Data Set (MDS) nurse updated resider	ıt	
		led a score of 15.0. The			care plans to reflect skin changes for		
	score indicated Resid	lent #2 was at a high risk of			actual or potential pressure wounds an	ď	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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		345128	B. WING _	<u>-</u>	02/23/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				520 VALLEY STREET	
ACCORDI	US HEALTH AT STAT	ESVILLE		STATESVILLE, NC 28677	
(X4) ID	SUMMARY	/ STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION (X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	
F 686	Continued From p	age 107	F 6	86	
	pressure ulcer dev	-		preventative interventions in p	lace All
	procedio dicor do	тегеритеги.		residents will continue to have	
	The quarterly Mini	mum Data Set (MDS)		assessed by the licensed nurs	
		11/24/21 revealed Resident #2		admission, weekly and with ch	•
	was cognitively int	act and had no behaviors of		skin condition and changes re	ported to
	rejection of care. T	The MDS indicated the Resident		physician with new wound trea	atments
		on for bed mobility and one		provided as ordered.	
		s. The Resident had a			
		er and was always incontinent		Address what measures will be	•
		S also indicated that Resident		place or systemic changes ma	
	#2 did not have a			ensure that the deficient practi recur:	ce will not
		ent #2's medical record		0.0/04/00 # 5: 4 614	
		ly skin assessments were		On 3/24/22, the Director of Nu	
	scheduled for Satu	urdays.		Charge Nurses educated facili	-
	A review of Reside	ent #2's weekly skin		agency Licensed Nurses and on the facility wound manager	
		01/15/22 and conducted by		policies. The licensed nurse w	
		ed no skin breakdown noted on		resident skin condition upon a	
	the assessment.	a no chiir broaktown notod on		weekly and with changes to id	
				changes in skin condition. The	-
	Several attempts v	were made to interview Nurse		will report skin concerns to the	
	#13 who performe	d the skin assessment on		nurse as identified during show	wers and
	Resident #2 on 01	/15/22 but the attempts were		routine activities of daily living	care. Skin
	unsuccessful.			concerns will be reported by the	
				nurse for follow up assessmer	
		ent #2's weekly skin		reported to the physician upon	
		01/22/22 and conducted by		treatment orders will be compl	
		l no skin breakdown noted on		care plan updated accordingly	
	the assessment.			hired facility and agency Licen and Nurse Aide staff will be ed	
	An interview was	conducted with Nurse #4 on		during orientation and prior to	
		PM. The Nurse explained she		during orientation and prior to	working
		g the weekly skin assessment		Indicate how the facility plans	to monitor
		new that the Resident did not		its performance to make sure	
		akdown when she did the		solutions are sustained:	
	assessment.				
				Effective 3/24/22, 5 residents	will be
	An interview was	conducted with Nurse Aide (NA)		audits for appropriate care and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATE	ESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			TION
F 686	#5 on 02/08/22 at assigned to work withird shift. The NA was alert and orient. The NA stated the bowel but because his lower body that he had a bowel moto be checked and explained that she worked with Reside ulcer being discover and changed his brins skin and reporte there. An interview was considered and oriented and continued to explain incontinent of bower movement, he could stated he did not not reported it to the continued to work with the could stated he did not not be sident #2 when have reported it to the continued to work with the could stated he did not not be sident #2 when have reported it to the continued to work with the could stated he did not not be sident #2 when have reported it to the continued to work with the could stated he did not not be sident #2 when have reported it to the continued to work with the could stated he did not not be sident #2 when have reported it to the continued to work with the could stated he did not not be sident #2 when have reported it to the continued to work with the could stated he did not not be sident with the could stated he did not not be sident with the could stated he did not not be sident with the could stated he did not not be sident with the could stated he did not not be sident with the could stated he did not not be sident with the could stated he did not not	ith Resident #2 on 01/24/22 explained that Resident #2 ted and could voice his needs. Resident was incontinent of of the decreased sensation in he did not always know when vement, so the Resident had changed routinely. The NA was not sure when she ent #2 prior to the pressure ered but that if she checked rief she would have looked at ed the pressure ulcer if it was conducted with Nurse Aide (NA) 1:00 PM. The NA was ith Resident #2 on 01/24/22 rird shift and on 01/26/22 third fined that Resident #2 was alert bould voice his needs. He in that the Resident was el and when he had a bowel diet the staff know. The NA office any skin breakdown on the changed him and would the nurse if he had. Onducted with Nurse Aide (NA) 11:50 AM. The NA was rith Resident #2 on 01/25/22 xplained that she noticed the Resident #2 during a brief ed it the nurse but could not nurse was that she notified.	F	of skin. Scheduled license assessments and nurse a sheets will be monitored to accuracy and completene ensure that the physician treatment is provided as o Monitoring will be complet or Charge Nurse three tim weeks then, weekly for 8 v. Results of these audits will monthly Quality Assurance further problem resolution Administrator will review the weekly audits to ensure an identified are corrected. Completion date: 3/25/202	ide shower o ensure ess and to is notified and ordered. ted by the DO nes weekly x 4 weeks. If be reviewed e Meeting for if needed, he results of ny issues	N	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING_			C 02/23/2022
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	01/25/22 first shift pri ulcer was discovered 01/27/22. The Nurse made aware of a pre right buttock. An interview was cor #16 on 02/05/22 at 1 assigned to work with second shift. The NA was alert and orienter and would let you kn movement. The NA did not remember the brief but if she had not she would have reported the last time he work had the NA would had the NA would had an interview was cor #17 on 02/07/22 at 1 assigned to work with first shift. The NA expalert and oriented an NA continued to explin continent of bowel change him every two stated Resident #2 did the last time he work had the NA would had the NA would had the NA would had an interview was cor #15 on 02/05/22 at 1 assigned to work with second shift. The NA discovered skin issue reported the issues to time. During an observation	ior to when the pressure of on Resident #2 on explained that he was not ssure ulcer on Resident #2's inducted with Nurse Aide (NA) 2:20 PM. The NA was in Resident #2 on 01/25/22 in explained that Resident #2 of and could voice his needs ow when he had a bowel continued to explain that she is last time she changed his oticed any skin breakdown, writed it to the nurse. Inducted with Nurse Aide (NA) 2:10 PM. The NA was in Resident #2 on 01/26/22 colained that Resident #2 was inducted with Resident was and you had to check and to hours if needed. The NA id not have a pressure ulcer led with him because if he lave reported it to the nurse. Inducted with Nurse Aide (NA) 0:40 AM. The NA was in Resident #2 on 01/26/22 in explained that when she les with the residents, she on the nurse on duty at the	F 6	86		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			1	C
NAME OF D	DOVIDED OD SUDDUED	343120	B. WIIVO		CTDEET ADDRESS CITY STATE ZID CODE	02/	23/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STAT	ESVILLE			520 VALLEY STREET		
				,	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	Continued From page 110		F	686			
	was lying in bed w	earing shorts and a brief. The					
	Resident explained	d that he has had a pressure					
	ulcer on his buttoc	ks on and off for several years					
	because he was pa	araplegic and did not have the					
	normal sensation f	rom his hips down. The					
	Resident continued	d to explain that last Thursday					
	(01/27/22) he was	sitting in his wheelchair and					
	started to smell a f	oul odor and when the					
	_	into bed, he realized it was a					
		t was draining. The Resident					
		Aide (NA) #9 helped him get					
		ot Nurse #12 to assess the					
		sident #2 explained that he					
		bowel and did not have the					
		of a bowel movement which					
		checked and or changed every					
		staff did not check on him every					
		ne rang his call light and then it					
		hours for the staff to answer					
	_	Resident stated he has not had					
		tober 2021 and the staff did not					
	•	h. The Resident also stated					
		not perform a weekly skin					
	assessment on hin	II.					
	An interview was c	conducted with Nurse Aide (NA)					
		3:20 PM. The NA confirmed					
		esident #2 on 01/27/22 day					
		ne pressure ulcer on the					
		e changed his brief and					
		ure ulcer to Nurse #12. The NA					
		in that Resident #2 did not					
		ensation below his hips, so he					
		ked and changed for bowel					
		two hours because he did not					
		he had a bowel movement.					
	,	t if she had noticed a pressure					
		she cared for Resident #2, she					
	would have reporte						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		1212312022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	o2/04/22 at 12:50 PM worked with Resident explained that the Region and told him the his backside and ask it. The Nurse continuated the pressure ulknew that after he aspressure ulcer on his pressure ulcer should reported before the pastage IV. The Nurse the pressure ulcer and reported it to Nurse ulcer and reported it to Nurse ulcer and reported it to Nurse with the Would A review of a Change dated 01/27/22 at 4:4 Nurse #12 revealed Status. The assessmasked Nurse #12 to a drainage coming from #12 observed a blace edges over the right approximately 10 x 4 Nurse cleansed the vand applied a dry drepressure ulcer to the Nurse #20, and notification in the state of	aducted with Nurse #12 on M. The Nurse confirmed he t #2 on 01/27/22 and esident called him into his at something was leaking on the difference of the Nurse could look at the difference of the Saw it and the sessed the stage IV or right buttock that the difference of the difference of the could cere before he saw it and the sessed the stage IV or right buttock that the difference of the difference of the could cere before he saw it and the sessed the stage IV or right buttock that the difference of the difference of the could cere before he saw it and the sesser ulcer developed to a difference of the could cere and applied a gauze dressing the sesses of the sesses of the could cere of the could cere of the could cere of the could cere of the could with wound cleanser the could with wound cleanser the could cere of the could with wound cleanser the could cere of the could with wound cleanser the could cere of the could with wound cleanser the could cere of the could with wound cleanser the could cere of the could cere of the could with wound cleanser the could cere of the could with wound cleanser the could cere of the could with wound cleanser the could cere of the could with wound cleanser the could cere of the coul	F6				
	02/03/22 at 10:20 AM she was notified of a pressure ulcer on Re 01/27/22 when Nurse	nd the Provider. Inducted with Nurse #20 on Inducted wit					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 686	but the WP had alrewas notified by Nurpressure ulcer, so sobtained a treatmer until the WP could of 02/03/22. A review of a Nursir 01/27/22 6:54 PM arevealed, Resident right buttocks. The aware and ordered Alginate dressing. Endressing change with the content of the system and it with in place for his stag.	cound Physician (WP) that day eady left the facility when she se #12 of Resident #2's she notified the WP and not order for the pressure ulcer consult with Resident #2 on any Progress Note dated and written by Nurse #20 #2 reported a wound on his Wound Physician was made Santyl ointment and Calcium Resident #2 tolerated the thino complaint of discomfort. Define PM during an interview with ained that the reason why the ent #2's pressure ulcer was not Administration Record for precause she was still learning as possible that she did not eactly. Inable to interview Nurse #17 the for Resident #2 pressure D1/29/22 to determine whether it was performed on 01/29/22. Inducted with the Staff dinator (SDC) on 02/10/22 at the explained that on 01/30/22 to perform the treatments on then she got to Resident #2, are was not a treatment order the IV pressure ulcer on his DC continued to explain that	F 6	86		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/25/2022
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 686	and reviewed the R found on 01/27/22 the WP for Santyl, absorptive dressing on the January 202 Record. The SDC splace on 01/30/22 treatment, but she dressing had a date. A review of Resider revealed an order obuttock with wound apply Santyl ointmedressing and cover every day shift and A review of the Wor 02/03/22 revealed I stage IV pressure umeasured 8.5 x 10. drainage and 100% was debrided with a tolerated well. The right buttock pressuapply Santyl ointmedressing and cover shift and as needed. During an interview (WP) on 02/04/22 at that she had previo #2 for a stage II prefold which was rescontinued to explain endured COVID an (UTI) which all thos decline in a resident	there was an order given by Calcium Alginate and an g so she initiated the treatment 2 Treatment Administration stated there was a dressing in when she initiated the could not remember if the e on it. In #2's Physician orders stated 01/30/22 to cleanse right cleanser, gently pat dry then ent and Calcium Alginate with absorptive dressing as needed. und Physician consult dated Resident #2 presented with a alcer to the right buttock that 5 x 1.4 and heavy serous on necrotic. The pressure ulcer a scalpel which the Resident treatment plan was to cleanse ure ulcer with wound cleanser, ent and Dakin's wet to dry with foam dressing every day	F 68		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _		,	C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	consult with Resident feel like the Resident medical decline. The facility called her on Resident #2's pressure to make sure should be foreigned to her. The WP states sensation that Reside that it was possible to develop in a five to sulcer of that magniture before it was on 01/2 changed the treatment ulcer and would controlled the routinely checking an incontinence, they we pressure ulcer before. An interview was controlled the pressure ulcer before the was on 02/05/2 explained Resident #2. An interview was controlled the pressure ulcer before the buttocks facility should have the reoccurring pressure that pressure ulcers resident whose health facility should have the res	and to explain that after the at #2 on 02/03/22 she did not to the was going through a rapid at WP explained that the 01/27/22 and informed her of the ulcer and she made at the consulted when she 02/03/22 and gave orders for the description given and that given the decreased that given the decre	F 6	86			
	Wound Physician (W The WP explained the routinely checking and incontinence, they we pressure ulcer before. An interview was continent and including paraplegian ulcer of the buttocks facility should have the reoccurring pressure that pressure ulcers resident whose health medical decline but I in a rapid state of declined.	AP) on 02/07/22 at 9:15 AM. That if the facility had been and changing Resident #2 for could have noticed the e it developed to a stage IV. Anducted with Resident #2's 22 at 8:00 PM. The Physician #2 was at risk for pressure ue to several comorbidities and a history of a pressure and for that reason alone the even more vigilant to e ulcers. The Physician stated can progress rapidly in a th was in a rapid state of Resident #2's health was not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		0.45400				l	C
		345128	B. WING			02/	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		520	REET ADDRESS, CITY, STATE, ZIP CODE VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	the facility administrative Registered Diet assessment to ensusufficient nutritional Physician stated it w#2 developed a presaw the Resident's was extremely disaremembered when the facility, they has susceptible he was they would try to prestated that in her open should have been in and skin checks be developed to a stage that worse case set up infection, seposteomyelitis was a severity of the presistated unfortunately leadership of a Direct consistent oversigh department for more A second interview #2's Physician on 0 Physician stated the found on the Reside was avoidable. On 02/04/22 at 11:3 made of Nurse #2 produced the gloves after washing the sufficient of the second interview #2 produced the gloves after washing the sufficient of the sufficient of the second interview #2 produced the gloves after washing the sufficient of	e IV pressure ulcer she notified ration for an air mattress and ician to conduct a nutritional ure the Resident received intake for wound healing. The was unfortunate that Resident ssure ulcer because when she stage IV pressure ulcer she ppointed because she the Resident was admitted to d a discussion about how for pressure ulcers and how event them. The Physician pointon the pressure ulcer dentified through routine care fore the pressure ulcer ge IV. The Physician explained enario was Resident #2 would posis and death and still a possibility because of the sure ulcer. The Physician y, the facility has not had the ector of Nursing and no t in the wound management	F	586			

AND DI AN OF CORRECTION INDESTRUCTION NUMBERS		` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 120 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	after washing his han ointment and a Calciu covered the dressing dressing. The Reside change was not painf During an interview was not painf the Wound Management was a full time wound Management On 02/07/22 at 11:00 notified of immediate The facility provided a allegation of immediate The facility provided a allegation of immediate The facility those resident likely to suffer, a serior result of the noncomposite of the control of the central (paraplegic), diabetes ulcer left gluteal fold r #2 has weekly skin as Saturdays. A skin as Saturdays. A skin as Saturdays.	dor then changed his gloves ds before he applied Santyl am Alginate dressing and with a large foam border nt stated the dressing ful. With the Administrator and dressing (DON) on 02/07/22 at ed that they were aware that then system in the facility on and the facility currently eated Wound Care Nurse as a priority on their list to hire will be responsible for the process. AM the Administrator was jeopardy. An acceptable credible the jeopardy removal on the swho have suffered, or out adverse outcome as a pliance: The revent and identify a gent #2 who was at risk for to the facility on 02/02/21 myelitis in demyelinating an ervous system as mellitus and Hx of pressure resolved 06/2021. Resident assessment scheduled on sessment completed by 15/22 and 1/22/22 revealed	F	686			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE	5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677	UZ/ZU/ZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 686	buttock was discover assessed the right I on 1/27/22 and call orders. Treatment v 2/3/22, the Wound III aright buttock pre a Stage 4 wound w 100% necrotic. Sca completed on the w Because all resident ulcers when skin chinterventions impler the following plan h Effective 2/7/22, the Nurses completed in 100% current fair residents with skin identified with channeported to the Phy Practitioner by the I orders obtained as Data Set (MDS) Nu plans to reflect skin potential pressure winterventions in place Specify the action the process or system is adverse outcome from the action will on 2/7/2022, the Action of Nursing (DON), For Operations, Director Management and North Residents of the right of the process	cm pressure ulcer on right ered. The Wound Nurse puttock wound for Resident #2 ed Wound Physician for was initiated on 1/27/22. On Physician evaluated Resident essure ulcer. Wound staged as ith heavy serous exudate and lpel debridement was round. Its are at risk for pressure ranges are not reported and mented to prevent breakdown, as been devised: E Licensed Nurses and Charge read-to-toe skin assessments cility residents to identify breakdown. Residents ges in skin condition were sician and/or Nurse cicensed Nurse and follow-up appropriate. The Minimum rise updated resident care changes for actual or wounds and preventative be. The entity will take to alter the failure to prevent a serious om occurring or recurring, and	F 686		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTR		(X3) DATE COMP	SURVEY PLETED
		345128	B. WING			C 02/23/2022	
NAME OF P	ROVIDER OR SUPPLIER	040120		STREET AD	DDRESS, CITY, STATE, ZIP CODE	02/	23/2022
				520 VALLE	EY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			/ILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	analysis. The QAPI o	e 118 ng to discuss root cause committee reviewed the ement policy for needed	F 6	86			
	cause analysis was o	wound management					
	assessments to ident skin impairments 1) f	ify and address resident acility management did not versight related to the facility					
	address resident skir implement wound pre	ssessments to identify, impairments and evention strategies) by the					
	formulated by the QA identified issue to inc audit/monitoring need	nurse aides. A plan was API committee to address the lude a review of education, ds, and QAPI committee iewing for compliance.					
	Nurses completed ed and agency Licensed the facility wound ma						
	wound care protocol Licensed Nurse and protocol on skin asse						
	Aides inspecting skin living (ADL) care suc incontinence care an	ne facility's protocol on Nurse during activities of daily h as when performing d bathing to identify and n resident skin condition to					
	the Licensed Nurse S to reduce the risk of a (turning/reposition, hy	Supervisor, d) interventions a pressure ulcer					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C)2/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	resident skin condition and with changes in complete body audition report skin concerns verbally, written and/care clinical alert. Note reported to the Phys Practitioner upon find for follow-up treatment communicated to Licon 2/7/22. Licensed receiving education of to work until complet will utilize a master ecompletion of education will also be for newly hired staff. Effective 2/7/22, all is skin assessments are will be audited to enscompleteness and to care and treatment is Physician. Monitoring DON or Charge Nurses will complete to confirm accuracy completed by the Licon These follow-up assed on (5) five residents Effective 2/7/22, the Nurses and Charge is suffective 2/7/22, the Nurses and Charge is suffered to the complete suffective 2/7/22, the Nurses and Charge is suffered to the complete suffered to the co	Licensed Nurse will review on upon admission, weekly condition. Nurse Aides will a during ADL care and will to the Licensed Nurse for via an electronic point of ew skin concerns will be dician and/or Nurse dings by the Licensed Nurse and Nurses and Nurses and Nurses and Nurses and Nurses and Nurse aides not be allowed and. The Director of Nursing amployee list to track attion. This responsibility was a Director of Nursing by the ry and Risk on 2/7/22. The included during orientation are accuracy and a ensure that preventative as in place as ordered by the great accuracy and to ensure that preventative as in place as ordered by the great accuracy and be completed by the great five times weekly. Director of Nurses or Charge as follow-up skin assessment as for the skin assessment as for the skin assessment as for the week.	F 6	36			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP 520 VALLEY STREET STATESVILLE, NC 28677	CODE	01/20/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 686	Continued From page care has been comp will be completed thre all shifts including were Effective 2/7/2022, the foliable of Nursing will be ultimplementation of the removal for this alleged. Alleged Date of IJ Reference in the facility Administrates and the facility Administrates of the complementation. On 02/11/22 the facility validated through recresident interviews an ursing staff. The facility formation regarding identification, weekly and treatment implementation on the Licensed Nurresidents skin condition in the continent care, turnshowers, bed baths.	leted routinely. These rounds ree (3) times weekly (across eekends). The Administrator and Director imately responsible to ensure is immediate jeopardy ged noncompliance. The administrator and Director imately responsible to ensure is immediate jeopardy ged noncompliance. The administrator and Director imately responsible to ensure is immediate jeopardy ged noncompliance. The administrator and Director imately responsible to ensure is immediate jeopardy ged noncompliance. The administrator and Director imately responsible to ensure is immediate jeopardy ged noncompliance. The administrator and Director imately responsible to ensure is immediate jeopardy ged noncompliance. The administrator and Director imately responsible to ensure is immediately ged noncompliance. The administrator and Director imately responsible to ensure is immediately ged noncompliance. The administrator and Director imately responsible to ensure is immediately ged noncompliance. The administrator and Director imately responsible to ensure is immediately ged noncompliance. The administrator and Director imately ged noncompliance. The administrator and Director imately responsible to ensure is immediately ged noncompliance. The administrator and Director imately ged noncompliance.				DAIL
	well as verbally reponurse in charge for the ducated the Licens assessments on admassessment days an Physician and/or Nuhired Director of Nurperform follow up skaccuracy of the skinthe Licensed Nurses care rounds to ensur	electronic health record and rting the changes to the he Nurse Aides. The facility hed Nurses to perform skin hission and weekly on skin do to report the findings to the rese Practitioner. The newly sing and or designee will him assessments to confirm hassessments performed by a rand will conduct incontinent recontinent care rounds do routinely. During a meeting				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		02/23/2022		
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/20/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
F 686	with the Administrate 02/11/22 at 4:38 PM allegation was imple ensured that ongoin would be maintained. The credible allegati immediate jeopardy 02/08/22 was validar 1. b. A review of Resided 01/31/22 revestage IV pressure ul gently pat dry, apply dressing and cover vevery day shift, and A review of Residen Administration Recorevealed the treatments.	or and Director of Nursing on they validated the credible mented as written and g auditing for compliance d. on for the removal of with a removal date of ted on 02/11/22. sident #2's Physician orders aled cleanse the right buttock cer with wound cleanser and santyl and Calcium Alginate with absorptive dressing as needed.	F 686	,			
	day shift revealed M assigned to Resider During an interview at 10:00 AM the Reson his pressure ulce 02/02/22. During an interview on 02/03/22 at 4:05 she could not do any so the treatment nur responsible for doing treatment nurse schoontinued to explain	with Resident #2 on 02/03/22 sident stated that the dressing r was not changed on with Medication Aide (MA) #2 PM the MA explained that y of the residents' treatments					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET TATESVILLE, NC 28677	, , ,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	would have been respective treatments. On 02/04/22 at 10:20 conducted with Nurse did not do the dressin on 02/02/22 because management team be not accept the responsed accept the response ac	AM an interview was a #20 who explained that she g change for Resident #2 she had informed the effore that day that she would sibility for doing a atments. The Nurse stated a management of that nor a concoming shift that the lone. Admitted to the facility on sees that included diabetes #18's care plan dated a Resident had a stage IV sacrum that was present on for the pressure ulcer would and would not develop ained by utilizing uded providing treatments resician. Im Data Set (MDS) #/22/21 revealed Resident that and had no behaviors the MDS indicated the indent with bed mobility and sistance of one staff for	F	386			
	catheter and was inco also indicated Reside pressure ulcer.	ontinent of bowel. The MDS nt #18 had a stage IV					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345128	B. WING _		_	C 02/23/2022		
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE		STREET ADDRESS, CITY, ST 520 VALLEY STREET STATESVILLE, NC 286				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	DATE		
F 686	A review of Resident dated 01/23/22 reve sacrum pressure ulcar apply Collagen and cover pressure ulcer two days on day shift. A review of Resident Administration Recorevealed, the treatm completed for Wedn. A review of the staffi day shift revealed Massigned to Resident During an interview Resident #18 on 02/Resident was sitting explained that the dr supposed to be char supposed to be char supposed to be char the dressing was no Resident stated that dressing to go days. During an interview on 02/03/22 at 4:05 she could not do any so the treatment nur responsible for doing treatment nurse scheworking the hall next would have been restreatments.	t #18's Physician orders aled, cleanse stage IV er with Dakin's solution, back with silver alginate rope, with foam dressing every it. t #18's Treatment rd (TAR) for February 2022 ent was not signed off as esday 02/02/22. In gassignment for 02/02/22 edication Aide #2 was t #18. and observation made of 03/22 at 2:30 PM the up in his wheelchair and ressing on his sacrum was niged every other day and was niged yesterday (02/02/22) but t changed yesterday. The it was not uncommon for his without being changed. With Medication Aide (MA) #2 PM the MA explained that y of the residents' treatments	F	886				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345128	B. WING _			02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689 SS=E	on 02/02/22 because management team be not accept the response medication aide's treat she did not remind the did she report it to the treatments were not compared to the treatments of the treatment of the t	g change for Resident #18 she had informed the efore that day that she would asibility for doing a atments. The Nurse stated a management of that nor a oncoming shift that the done. with the Administrator and rsing (DON) on 02/07/22 at ed that they were aware that ent system in the facility on and the facility currently ated Wound Care Nurse a priority on their list to hire will be responsible for the process. ards/Supervision/Devices (2)		How corrective action will be accomplished for those resident have been affected by the defici practice; The facility failed to complete ar	ient	3/25/22	
		(Resident#3) for 1 of 3 r accidents and failed to		The facility failed to complete ar smoking assessment to determine	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			1	C / 23/2022	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	723/2022	
					20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677			
					TATESVILLE, NC 20077			
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F 689	Continued From page	e 125	F 6	889				
	secure a full oxygen tank that was left lying on a table in the facility chapel where residents and staff were noted to visit intermittently for 1 of 1 chapel observed.				resident was a safe smoker or needed supervision while smoking cigarettes for resident #3. Resident #3 smoking assessment was updated on 2/7/2022 reflect residents ability to smoke safely	to		
	The findings included	:						
	1a. Resident #3 was readmitted to the facility on 12/07/20 with diagnoses that included bilateral amputation to lower extremity, heart disease, dementia, and others.				The facility failed to investigate a fall resident #3. On 3/10/22, the licensed nurse completed an incident report and updated resident fall care plan.			
		00/00/04			The facility failed to secure a full oxyge			
		n 08/30/21 read in part,			tank that was left laying on a table in th			
		ctivity of daily living self-care			facility chapel. Oxygen tank removed f			
	· ·	elated to history of dementia			chapel on 2/7/2022 and properly stored	ın c		
	goal read; Resident#	tremity amputations. The 3 will maintain/improve			designated oxygen storage room.			
		on in activities of daily living			How the facility will identify other reside			
	included: Resident #3	eriod. The interventions B required total assistance and 2-person assistance to			having the potential to be affected by the same deficient practice;	ne		
	transfer.	•			Effective 3/14/2022 the Director of			
					Nursing (DON) and/or designee asses	sed		
	The significant chang	e Minimum Data Set (MDS)			current residents that smoke to ensure			
	dated 12/15/21 indica	ited that Resident #3 was			smoking assessments and care plans			
		required total assistance			were updated and accurate.			
	with transfers. The M							
	Resident #3 had 1 fal previous assessment	I with no injury since the .			Effective 3/14/22, the DON and/or designee reviewed residents will fall incidents between 2/7/22 and 3/7/22 to	1		
		s incident and accident log			ensure appropriate investigation, incide	ent		
	for December 2021 revealed no falls were reported for Resident #3 on 12/22/21.				report and care plan revisions were ma No additional concerns identified.	ide.		
	02/01/22 read in part, amputee and required	e Area Assessment dated Resident #3 was a double d assistance with transfers d during the review period.			On 3/14/22, the DON completed an au by rounding observations to ensure all portable oxygen tanks not currently in were properly stored in designated oxy room. No additional concerns identified	use gen		

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C	
NAME OF D	DOVIDED OD CUIDDUED	343126	B. WING		TREET ARRESCO CITY STATE ZIR CORE	02/	/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET			
				S	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	were conducted on 0. Resident #3 was rest stated that he recalled 12/22/21. He denied stated that when the stated that when the stated the lift to go my wheelchair. Nurse Aide (NA) #8 wat 3:39 PM. NA #8 co working on the COVII NA #7 came over and help get Resident #3	nterview with Resident #3 2/02/22 at 8:32 AM. ing in bed and was alert. He d falling from the bed on any injury from the fall and staff finally came in to help, et him off the floor and up to vas interviewed on 02/02/22 enfirmed that she was D-19 unit on 12/22/21 when d asked me and NA #9 to off the floor. NA #8 stated	F	689	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur: Effective 3/24/2022, Director of Nursing and/or designee educated current faciliand agency licensed nurses on assess residents for smoking status and completion of smoking assessment and care plan. The licensed nurse will complete smoking assessments upon admission, quarterly and with changes resident smoking status.	ot g ity sing d		
	that when she entered Resident #3's room on 12/22/21 he was sitting on his buttock and denied any pain or injury. The floor had a puddle of liquid on it that had to be cleaned up before we could get Resident #3 off the floor. NA #8 stated that they "cleaned up the liquid that was on floor and then put the lift pad under Resident #3 then transferred him from the floor to his bed." Once Resident #3 was back in the bed NA #8 stated she and NA #9 returned to the COVID-19 unit to finish their shift.				Effective 3/24/2022 Director of Nursing and/or designee educated current facili licensed nurses on investigating a fall a completing an incident report. The licensed nurse will complete an incider report following a resident fall and will update care plan. Effective 3/24/22, the DON and/or designee provided education to license nurses, certified nursing assistances at transporter on ensuring proper storage	ity and nt ed nd		
	were working on the of asked by NA #7 to he floor, so we walked to she could not recall with that Nurse #14, NA # in the room and there could not tell if it was that they had to clear get Resident #3 off the sitting on his buttocks.	12/22/21 she and NA #8 COVID-19 unit and were elp get Resident #3 off the over to help. NA #9 stated what time it was but stated 7, NA #8, and herself were e was a liquid on the floor but urine or water but stated in that up before they could the floor. Resident #3 was is between the 2 beds in the lenied any pain or injury. NA			portable oxygen tanks. Newly hired facility and agency license nurses will receive education during orientation and prior to working. Indicate how the facility plans to monitorits performance to make sure that solutions are sustained: Director of Nursing and/or designee will audit 5 residents for accurate, complete	or II		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345128	B. WING _			o	2/23/2022	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
				5	520 VALLEY STREET			
ACCORDI	US HEALTH AT STATE	ESVILLE		5	STATESVILLE, NC 28677			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 689	Continued From pa	age 127	F 6	689				
	#9 stated that and	once the liquid that was on the			smoking assessments and care plans	and		
	floor was cleaned ι	up, they used the lift and			resident falls for proper investigation,			
	transferred Resider	nt #3 back to the bed and once			incident report and care plan revision.			
	he was back in the	bed, they (NA #8 and NA #9)			Monitoring via observational rounding	will		
	returned to the CO'	VID-19 unit to finish their shift.			be completed to ensure proper oxyger	í		
					storage.			
		wed on 02/03/22 at 10:46 AM.			Monitoring will be completed 3 times			
		at she had worked on			weekly for 4 weeks then, weekly for 8			
		nitially responsible for			weeks.			
		ly after arriving at work on						
		ated that the former Director of			Results of these audits will be reviewe			
	_ , ,	ed a meeting with all staff to			monthly Quality Assurance Meeting for	•		
		residents including Resident			further problem resolution if needed.	.14		
		tive for COVID-19. Resident #3			Director of Nursing will review the resu of weekly audits to ensure any issues	แร		
	•	ned to his room since he was in NA #7 stated that she had			identified are corrected.			
		erns with taking care of			identified are corrected.			
		his current COVID-19 status			Completion date: 3/25/2022			
		d that she would provide care			Completion date: 0/20/2022			
		ase the hesitation that NA #7						
		that when breakfast trays						
		Nurse #14 had taken Resident						
		into him and when he was						
		set outside of his door. Then						
	· ·	ntered Resident #3's room to						
	deliver his lunch tra	ay she found him on the floor.						
		ed that the DON had been in						
	the room around 10	0:30 AM - 11:00 AM and						
	provided care to hir	m and then when Nurse #14						
	entered the room a	round 12:30 PM she found						
	Resident #3 on the	floor. NA #7 stated that the						
	floor in Resident #3	3's room was a mess with						
	either urine or wate	er and tissue and stated she						
	l '	the DON assuming she would						
	get him off the floor	r. She stated that she quickly						
		ON was not going to come and						
	get Resident #3 off	the floor and since she was						
		elf that day, she went and						
	found NA #8 and N	A #9 and asked them to come						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING				22/2022
NAME OF P	ROVIDER OR SUPPLIER	0.0.20		S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022
NAME OF T	NOVIDER OR SOLT LIER				20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 689	Continued From page	e 128	F	689			
	stated that Nurse #14 he had no injuries and cleaned the floor up N were able to get Resi back to bed and NA # lunch and he was abl that.	t #3 off the floor. NA #7 assessed Resident #3 and d denied any pain. After they NA #7, NA #8, and NA #9 dent #3 off the floor and f7 stated she warmed up his e to feed himself lunch after rse #14 were made on 2 without success.					
	11:20 AM. The former she had met with the facility had some resippositive for COVID-19 During the meeting the voiced some concern Resident #3 with his of her that I would provid day. The DON stated #3's room early that mand emptied his urinar was made aware that DON could not recall floor but stated that N completed the incider the fall in the medical she did not even think stated retrospectively the time she did not to Normally after a fall the done and then the fall following morning in to care plan updated at that did not happen were residued.	e including Resident #3. If a DON stated that NA #7 Is in providing care to COVID-19 status so I told de care to Resident #3 that that she went into Resident morning and checked on him all then around 10:30 AM she is he was on the floor. The who got Resident #3 off the durse #14 should have introport and documented record. The DON stated is about it being a fall and it was certainly a fall but at hink about it being a fall.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			02/2	; 23/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	, , , , ,	0.2022		
ACCORDI	US HEALTH AT STATES	VILLE		520 VALLEY STREET STATESVILLE, NC 28677					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE		
F 689	stated that the fall she and an incident report have then been discustand-up meeting hel Administrator stated seriod resident about the fall #3 told her about the expected the nursing required paperwork. 1b. Review of a facility Smoking implemente residents will be asked the admission process or comprehensive Mil assessment process. be further assessed us Smoking Assessment smoke at all. If a residences any decl	d current DON were (22 at 3:40 PM. The DON build have been investigated at completed. The fall should assed in the facility's clinical at the following morning. The she had spoken with the and indicated that Resident fall as well and she staff to complete the sy policy titled: Resident at 11/01/20 read in part; All ad about tobacco use during s, and during each quarterly nimum Data Set (MDS) Resident who smokes will using the Resident safe at, to see if resident is safe to	F	589					
	Resident #3 was read 12/07/20 with diagnor amputation to lower edementia, and others Review of a Safe Sm 09/07/21 indicated the smoker. The assessm #15. Review of a care plant	dmitted to the facility on ses that included bilateral extremity, heart disease,							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	through the review of included: instruct reshazards and about sinstruct the resident smoking, monitor or nurse immediately if violated the facility sclothing and skin for the resident requires. The significant chandated 12/15/21 indictoronic cognitively intact and assistance with activalso indicted that Research and the courty smoking a cigarette present it the courty. An observation of R 02/02/22 at 11:42 Al outside in the courty smoking a cigarette present it the courty. An observation of R 02/03/22 at 11:55 Al outside in the courty smoking a cigarette present in the courty. Nurse #10 was inter PM. Nurse #10 conf Manager for Reside Resident #3 began garound 3-4 weeks a	smoke without supervision date. The interventions sident about smoking risk and smoking cessation aides, about the facility policy on all hygiene, notify charge it is suspected resident has smoking policy, observe is sign of cigarette burns, and is supervision while smoking. The motion of the smoking of the supervision while smoking. The motion of the smoking of the supervision while smoking. The motion of the smoking of the supervision while smoking. The motion of the smoking of the supervision while smoking. The supervision while smoking of the supervision while smoking. The motion of the supervision of the supervision while smoking. The motion of the supervision of the supervision with a supervision while smoking of the supervision with a supervision with a supervision of the supervision of	F	589			
	started smoking aga not complete his sm	nin. Nurse #10 stated she did loking assessment so she was an independent smoker					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			1	23/2022	
	ROVIDER OR SUPPLIER	VILLE		520	REET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET TATESVILLE, NC 28677	1 02/	23/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 689	him when he was sm. The Activities Directo 02/07/21 at 2:31 PM. worked at the facility aware that Resident weeks ago. She state to smoke whenever had to be present with Attempt to speak to N 02/06/22 and again on The Administrator and (DON) were interview. The Administrator state Resident #3 smoke be we should have asse confirmed that Reside updated smoking asset they would speak to be programs to see if he as Review of a facility implemented on 11/0 Storage-cylinders will supported in racks or portable carts, approved in the chapel visiting. An observation was made and the chapel visiting.	r (AD) was interviewed on The AD stated that she had since July 2020 and was not #3 smoked until about 2 and that Resident #3 went out the wanted to, and no staff in him as far as she knew. Jurse #15 was made on no 02/07/22 without success. Id current Director of Nursing and on 02/07/22 at 3:40 PM. It that she had never seen ut if he was smoking then seed him. The DON ent #3 should have an essment and indicated that him about smoking cessation was interested. policy titled, Oxygen Safety 1/20 read in part; Oxygen be properly chained or other fastenings (i.e. sturdy yed stands) to secure all whether connected,	F	689				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER US HEALTH AT STATES			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		2/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	An observation was not all the control of the facility chap cylinder tank lying on anyway. Numerous so out of the chapel thrown of the chapel thrown anyway. There was a in the chapel visiting, were in and out of the chapel visiting. The Administrator was 3:40 PM. The Administrator was 3:40	nade on 02/03/22 at 11:11 pel. There was a full oxygen a table not secured in aff members were in and ughout the day. nade on 02/04/22 at 9:00 pel. There was a full oxygen a table not secured in resident noted to be sitting Numerous staff members be chapel throughout the day. ducted with the acting PON) on 02/04/22 at 4:34 that the oxygen cylinder and on the table it should be be storage rack. Is interviewed on 02/07/22 at estrator stated that the ave been secured. She bow how it got put on the had a meeting in the chapel hertain if the tank had been be seen it and taken care of it. Iff (2) Staff. Is sufficient nursing staff with eletencies and skills sets to belated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care	F 6			3/25/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		ZIZJIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	accordance with the fat §483.70(e). §483.35(a)(1) The fat by sufficient numbers types of personnel or nursing care to all resresident care plans: (i) Except when waive this section, licensed	city's resident population in facility assessment required cility must provide services of each of the following a 24-hour basis to provide cidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not	F 7	25		
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation resident and staff into maintain sufficient stadignified manner to puspoken rudely to, to pushen requested, to retriple briefing the resident's request to preferred time of day maintain sufficient stading and complete baseling plans and failed to consume a sufficient staff to prove Physician ordered metallicents and to maintain sufficient maintain sufficient staff to prove the province of the sufficient staff to maintain sufficient maintain ordered metallicents and failed to maintain sufficient staff to prove the sufficient staff to prove the sufficient staff to maintain sufficient staff to maintain sufficient staff to prove the sufficient staff to prove the sufficient staff to maintain sufficient staff to prove the suffi	ns, record reviews and reviews, the facility failed to affect to treat residents in a revent a resident from being provide incontinence care afframe from double and dents and failed to honor a get out of bed at his. The facility also failed to aff to develop, implement and comprehensive care mplete resident cility failed to maintain ide scheduled showers and adications. The facility ain sufficient staff to provide atments for wounds and vices to maintain skin		How corrective action will be accomplished for those resident have been affected by the defici practice; 1) F550 The facility failed to treat resider dignified manner when requestimedication for resident #4. On 3 Administrator provided 1:1 reed MA #1 on speaking to residents dignified manner. The facility failed to treat resider dignified manner by not providing incontinence are when requested double, triple briefing resident #4 5, resident #9, residents received.	nt in a ng 8/7/22 ucation to in a nt in a ng ed and 3, resident nd resident	

NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	ATE SURVEY DMPLETED
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	C 02/23/2022
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
	(X5) COMPLETION DATE
F 725 Continued From page 134 F 725	
residents in the areas of dignity, choices, activities of daily living, Minimum Data Set assessment completion and accuracy and baseline and comprehensive care plans, quality of care and pressure ulcer care (Residents #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12, #14, #15 and #18). The findings included: This tag is cross referred to: 1. F-550 Based on observations, record review, cell phone video footage, resident and staff interview the facility failed to treat a resident in a dignified manner when a medication (Resident #4), failed to treat a resident is in a dignified manner by not providing incontinence care when requested and double and triple briefing the residents (Resident 3, Resident #5, Resident #8, Resident #10, and Resident #11) for 6 of 9 residents reviewed. The residents stated that waiting on incontinence care and wearing multiple briefs made them feel bad, low like less of a man, demeaning, embarrassed and degraded. 2. F- 561 Based on observations, record reviews and staff and Resident interviews, the facility failed to honor a resident #5 request to get out of bed at preferred time of day. Resident #5 request was honored on 2/11/2022 and care plan/task list updated to reflect resident preferred time of day. F636 The facility failed to complete a Comprehensive Minimum Data Set assessment on 1/10/22 transmitted and accepted on 2/2/22. Resident #3, was transmitted and accepted on 2/2/22. Resident #6 was transmitted and accepted on 2/7/22. F641 The facility failed to accurately code an Admission Minimum Data Set for resident #4. The facility failed to complete observed to the facility failed to comprehensive Minimum Data Set assessments with the subsequent care area assessment on 10/28/2021 and retransmitted on 3/4/2022.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING_				C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 021	23/2022
					20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	e 135	F7	725			
	reviewed (Resident # Resident #7).	3, Resident #6, and			"height" on admission on 10/28/2021 a retransmitted on 3/4/2022.	nd	
	resident, staff, and fa facility failed to provide requested by the resi #5, Resident #9, Res failed to provide show Resident #7, and Resident reviewed for 5. F-641 Based on reand resident interview accurately code an accurately code an accurately code and assessment for height of 3 residents review 6. F-655 Based on reinterview the facility facare within 48 hours of surgical wound care of	activities of daily living. cord review, and facility staff vs, the facility failed to dmission minimum data set ut and discharge planning for			F655 The facility failed to develop a baseline care plan in the area of smoking and surgical wound care within 48 hours of admission for resident #6. F657 Resident #1 comprehensive care plan revised on 2/7/2022 by the licensed nut for use of anticoagulant medication. Resident #2 comprehensive care plan revised on 2/7/2022 by the licensed nut for care of pressure ulcer. F677 Resident #2, resident #7 resident #12 to list updated for bathing type and frequency preference and residents continue to receive showers per plan of care.	irse irse task	
	Coumadin therapy (R resident reviewed for #2). 8. F-684 Based on obresident, and staff interfollow physician orderstasis ulcer (Resident)	failed to revise plans in the areas of of 1 resident reviewed for desident #1) and 1 of 1 pressure ulcer (Resident deservations, record review, derview the facility failed to are for treatment to a venous t #7), failed to follow destment to a diabetic foot			#5, resident #9, resident #10 and resid #11 will continue to be provided to maintain incontinence care needs. F684 Treatment for resident #7 venous statis ulcer was provided on 3/3/2022 and wi continue to be provided as ordered by physician. Treatment for resident #18 diabetic for ulcer was provided on 3/5/2022 and wi continue to be provided as ordered by physician. The facility failed to follow physician or	ent II the tthe tthe	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		TE SURVEY MPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•		
				520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
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F 725	Continued From page	2 136	F 72	25			
	(Resident #6) for 3 of	eatment of surgical wounds 5 residents reviewed.		for treatment of surgical wou resident #6. Resident discha 2/8/2022.			
		oservation, record reviews,					
		d Physician and Physician		F686	1:1 (26		
	interviews the facility			The facility failed to prevent a			
		services to maintain skin twith a history of skin		pressure ulcer Resident #2 v	vno was at		
	breakdown. Resident	•		risk for pressure ulcers.			
		ling a foul odor and was		On 2/3/22, the Wound Physic	cian		
		e IV pressure ulcer (the		evaluated Resident #2 right l			
		come very deep and as the		pressure ulcer. Wound stage		as a Stage	
	-	e or bone may be visible,		4 wound with heavy serous 6	_		
	T	ong possibility if not cared		100% necrotic. Scalpel debri			
	_	ck. The facility also failed to		completed on the wound and			
	provide pressure ulce	er treatments for 2 of 3		implemented. Resident #2 w	ill continue to		
	residents (Resident#	2 and Resident # 18)		receive wound care to heal a	ind prevent		
	reviewed for pressure	e ulcers.		further skin breakdown. Care	•		
	On 02/02/22 at 7:00	M on intoniou was		updated by MDS Coordinato	r.		
	On 02/02/22 at 7:00 A	aw an interview was e #4 who worked the 7:00		2) Effective 2/14/2022 Adm	viniatrator and		
		The Nurse explained that it		2) Effective 3/14/2022 AdmDirector of Nursing complete			
		have 4 nurses and 4 to 5		current staffing levels to dete			
		itly the staffing had been		sufficient staffing needed to			
		nich meant the nurses work		resident care is provided to a			
	would often get behin			choices, activities of daily livi			
		the nurse aides take care of		Data Set assessment comple	-		
		rse continued to explain that		accuracy and baseline and			
	it was the case last w	eekend (01/28/22, 01/29/22		comprehensive care plans, q	uality of care		
	and 01/30/22) that the	ere was only 3 nurse aides		and pressure ulcer care. As a	a result of this		
	_	e facility did not have staff to		review, the facility has posted			
		staff would come in to work		job openings for multiple lice			
		best they could to take care		and nurse aides. The facility			
		Nurse stated the residents		full-time wound nurse and sta			
	_	ers on second shift because		development coordinator and			
	there was not enough them their showers.	n staff scheduled to give		recruitment and retention effort	orts ongoing.		
	uloni ulon showers.			3) Administrator provided e	education to		
	On 02/02/22 at 7:20 /	AM an interview was		staffing coordinator on staffin			

AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
	345128	B. WING			C)2/23/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,	
			520 VALLEY STREET		
ACCORDIUS HEALTH AT STATESVIL	LE		STATESVILLE, NC 28677		
PREFIX (EACH DEFICIENCY N	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725 Continued From page 1	37	F 72	25		
conducted with Nurse # was hired to be the Treat vaccine mandate came did not get vaccinated with short of nurses and now working as a hall nurse. Nurse for at least 2 weet to explain that she had a facility's electronic medit wound management poon 02/02/22 at 8:25 AM conducted with Nurse # worked the night shift. The staffing was hit or misson agency staff that will not scheduled to work, and the Nurse continued to case last night when he aide because they were Nurse indicated that it do agency staff to come in come in and work. On 02/02/22 at 11:03 All conducted with the School she staffed the nursing the daily resident censure utilize a total of 27 nursing a mixture of nurses and period. The Scheduler of she normally could meet since the mandated vacustaffing had become more was struggling to meet to because the facility lost.	20 who explained that she atment Nurse but the out and a lot of nurses which made the facility when she had on the hall and not the Treatment less. The Nurse continued not been oriented to the cal record system or the licy. I an interview was 11 who stated he normally the Nurse explained that because they utilized to show up when they were it put the facility in a bind. explain that it was the had to work as a nurse is short of nurse aides. The id not do any good to call because they would not What interview was eduler who explained that department according to show and currently she could not individuals which was nurse aides in a 24 hour continued to explain that it the staffing numbers but coine came into effect, ore challenging and she the minimum staffing	F 72	ratios/PPD level and resident ac Education completed on 3/10/2: Administrator and DON will revi resident acuity and census to destaffing levels and will share this information with the staffing coording of appropriate staffing each shi Staffing needs will be reviewed morning meeting and determine needs reported to staffing is provensure resident care is provided dignity, choices, activities of dai Minimum Data Set assessment completion and accuracy and be and comprehensive care plans, care and pressure ulcer care. 4) Administrator or designee to schedules, daily staffing sheets labor reports, actual employees in the building along with callout the schedule appropriately to enadequate staffing to meet residenceds. Monitoring will be compificated for 4 weed 3x/week for 4 weeks, then 1x/w weeks. The Administrator or designer to design the summer of the provement meeting monthly to the schedule appropriately to enadequate staffing to meet residence and Performance Improvement meeting monthly to the schedule and take recommendation process improvement and make changes to the plan as necessal maintain compliance with sufficients staffing.	2. The ew etermine sordinator ff/day. in daily ed staffing linator to ided to d to assure ly living, asseline quality of to audit , daily presence to adjust asure leted at a ks, then eek for 4 signee will fality to present ons on any es ary to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	being short staffed an her to over staff the staffer to short staffing. She staffed for 2 aided to be scheduled to ginhad call outs or no carearrange the staffing the showers fell on the stated there was no a staff and they had to and when they could on 02/03/22 at 10:46 conducted with Nurse explained she normal usually had 24 reside activities of daily living them if they required changing them every incontinent, getting their showers if schellights when possible that on that day, she residents twice and finot able to provide the was she able to provide the shower their teeth becomes the staffer of the staffer and putting the staffer showers if schellights when possible that on that day, she residents twice and finot able to provide the was she able to provide the shower their teeth becomes the staffer and the staffer	ch resulted in the facility and the facility would not allow shifts in order to compensate The Scheduled stated that es on first and second shifts es es showers but when they all no shows they had to g pattern and the workload of the floor staff. The Scheduler accountability for the agency utilize what they could get get them.	F 7	'25		
	conducted with Nurse explained that the sh kept up to date so the to look through the e	ower schedules were not e nurse aide had to take time lectronic record for each ssigned to in order find out				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		0.45400	D. MING				С	
		345128	B. WING _			02	/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT STATES	VIIIF			520 VALLEY STREET			
ACCONDI	OO HEAEITHAI OTATEO	VILLE		;	STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	Continued From page	e 139	F 7	725	5			
	continued to explain	that when there was enough						
		ve a shower team then the						
	shower team would b							
		ely there have been no extra						
		ve the showers. The NA						
		0 PM to give the showers						
		sible to give showers then						
		ents received their showers.						
		ducted with Nurse #2 on						
		The Nurse stated he						
		1 to 7:00 PM and explained						
		cult because of all the call						
		explain that he felt that the						
		ficient staffing was the						
		he Nurse explained that if						
		nd nurse then the nurse on						
		edication aide had to cover						
		n that the nurse had to do						
		ne medication aide cannot						
		ued to explain that some						
		e to be responsible for both						
		can get so hectic that it is						
		done. The Nurse stated he						
		reatments go and he has						
	also had to do extra t							
		er shift that did not get done.						
		thought Nurse #20 was a						
		e was not scheduled to do see she had to work the hall.						
		that the aides did not water nor do they give						
	showers because of							
	During an interview w	vith Nurse #12 on 02/03/22						
	_	e explained that the facility						
		ere was no administrative						
		e the systems. The Nurse						
		as short, and the residents						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION G	COMPLETED
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	OLIZOIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 725	explained that there made it difficult for the wound treatmer have a huge workloresidents and working have to cover the homological or the problem miscommunication. Was no one responsions the dule to ensure assigned to work care as a supplica	they needed. The Nurse was no wound nurse which he hall nurses because it put not not not not not not not not not no	F 72	5	
	so she decided to g aide and who worked come and help ther that it was not unus only 2 nurse aides if for as many as 40 r made it difficult to p needed. On 02/04/22 at 3:23 Nurse Aide (NA) #2 asked to come into because the facility	et her friend who was a nurse ed in a different building to nout. The Nurse explained ual for third shift to work with n the building to provide care esidents a piece and that rovide the care the residents B PM during an interview with 0 she explained that she was the facility and work as a NA was short staffed and needed ated when she got to the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	72.20.2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	JLD BE COMPLETION
F 725		PM she was given an	F 72	5	
	staff on duty had not PM because they did staff did not show up to explain that she h	ents that according to the the the theen attended to since 7:00 do not know that the scheduled to to work. The NA continued and to change multiple the the the the the the the the the th			
	conducted with Nurs he was agency staff shift and worked an week for the facility. staffing at the facility since they mandated continued to explain all the work done an	PM an interview was se Aide (NA) #12 who stated that worked second and third average of 5 to 6 days a The NA explained that was very short especially d the vaccine. The NA that it was unrealistic to get d take care of the residents ed but you had to do the best			
	conducted with Nurshe was agency staff shift. The NA explair bad" because the fa facility staff and the NA continued to exptimes that he has ha himself which means take care of and proliving by himself. The	O PM an interview was se Aide (NA) #17 who stated who worked first and second ned the staffing was "pretty cility did not have but 5 or 6 rest was agency staff. The lain that there have been d to work the whole unit by t he had about 50 residents to vide all their activities of daily e NA stated he had to do the e care of the residents.			
	(MDS) Nurse on 02/ explained that the M left and the workload	with the Minimum Data Set 08/22 at 11:50 AM the Nurse IDS Coordinator had recently d of the Resident Assessment ocess was left to her. She			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATE			STREET ADDRESS, CITY, STATE, ZII 520 VALLEY STREET STATESVILLE, NC 28677	P CODE	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BI O THE APPROPRIA	5.475
F 725	Continued From page continued to explain year's experience we felt like she was still was very overwhelm to do. On 02/03/22 at 11:2 conducted with the felt (DON) who explained as the Nurse on the and was not able to and monitoring systemonitored. The DON facility was constant the residents did no and needed becaus stated before she let the Administrator has about short staffing being monitored and On 02/07/22 at 3:40 conducted with the Administrator of Nursing acknowledged that facility was an area attention. The DON Corporation to be all	ge 142 It that she only had about a lith the RAI process and she learning the process which hing when it was all up to her 3 AM an interview was former Director of Nursing at that she spent many days cart because of short staffing do her duties as the DON lems that needed to be in continued to explain that the ally short of nurse aides and at get the care they required the of short staffing. The DON off ther employment, she and and multiple conversations and how systems were not at followed. PM an interview was and interim (DON). The two the lack of staffing in the that needed immediate stated she has asked the ole to increase the number of	F 7	DEFICIE		
	obtain new agency of staff in the facility. Thas asked the Corp Certified Wound Nu in order to manage facility. The Administ that a new Director would be starting in Administrator stated	Administrator was trying to contracts in order to get more the DON explained that she coration permission to add a rese position for 7 days a week the wound situation in the strator continued to explain of Nursing was hired and a couple of days. The she was unaware that the MDS) assessments were				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
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		345128	B. WING _			02/	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	ODE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 725	know that the MDS N the complete process sure that the MDS Nu	e 143 ubmitted and also did not lurse did not know how to do so but that she would make urse received Corporate of the Resident Assessment	F.	725			
F 726 SS=E	Competent Nursing S CFR(s): 483.35(a)(3)(§483.35 Nursing Serv	(4)(c)	F	726			3/25/22
	the appropriate comp provide nursing and r resident safety and at practicable physical, I well-being of each res resident assessments and considering the n diagnoses of the facil	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required					
	licensed nurses have and skill sets necessaneeds, as identified the	cility must ensure that the specific competencies ary to care for residents' hrough resident escribed in the plan of care.					
	limited to assessing,	ing care includes but is not evaluating, planning and it care plans and responding					
	to demonstrate comp	ure that nurse aides are able etency in skills and y to care for residents'					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NI IMPED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			۰,	C 2/23/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02	212312022
NAME OF T	NOVIDEN ON OUT FIELD				0 VALLEY STREET		
ACCORDI	US HEALTH AT STATI	ESVILLE					
				51	FATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 726	Continued From pa	age 144	F7	726			
		described in the plan of care. NT is not met as evidenced					
	by:	INT IS HOLIHEL AS EVIDENCED					
	'	tions, record review, and staff			How corrective action will be		
		y failed to ensure Nurse Aide			accomplished for those residents foun	d to	
		ty specific training and			have been affected by the deficient	u to	
		ork as a nurse aide for 1 of 5			practice;		
	staff members revi				F,		
	The findings includ	led:			The facility failed to ensure Nurse Aide #20 had facility required training and		
					competencies to work as a nurse aide		
		nterviewed on 02/04/22 at 3:15			Nurse Aide #20 is not employed by the		
		nfirmed that she had worked			facility and therefore no corrective acti	on	
		on third shift 02/03/22. She			is possible.		
		ought they had five Nurse Aides at shift but sometime around			How the facility will identify other resid	onto	
		ed that they did not have five			having the potential to be affected by t		
		they only had three. Nurse			same deficient practice;	i i C	
		she tried to the call the			same denoient practice,		
		Scheduling Coordinator (SC) to			Effective 3/14/2022 Director of Nursing	נ	
		ng some help in and were			and/or designee reviewed nurse aide	,	
		uch with them. Nurse #19			staffing to ensure they received trainin	g	
		nat her best friend who was an			and competencies before working in the	-	
	agency NA that wo	rked in a different part of a			facility.		
		/ and had worked in other			Address what measures will be put int	_	
		as at her house for the alled her (NA #20) and asked			Address what measures will be put interplace or systemic changes made to	J	
	· ·	facility and help and she			ensure that the deficient practice will n	ot	
		stated she briefly left the			recur:	Οί	
		house and pick up NA #20 and			roodi.		
		facility to help. Nurse #19			Effective 3/24/22, current facility and		
		#20 had never worked at the			agency nurse aide were audited to ens	sure	
		they were short and needed			proper training and competencies.		
		agreed to come and help.			Additional education and skills		
	·	•			competencies completed by the licens	ed	
	NA #20 was intervi	ewed on 02/04/22 at 3:23 PM.			nurse to ensure all nurse aides are tra	ined	
	NA #20 confirmed	that she was staying at Nurse			and competent to provide resident car	e.	
	#19's house for the	e weekend and got a call					
	around 10:00 PM o	on 02/03/22. She stated that			Effective 3/24/2022 Staffing Developm	ent	

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID IN	<u>J. 0930-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		SURVEY PLETED
							С
		345128	B. WING			02	/23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	WILLE		52	20 VALLEY STREET		
ACCONDI	OSTILALITIAI STATES	VILLE		S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From pag	e 145	F	726			
		could come to the facility and			Coordinator or designee will ensure		
		ere short staffed. NA #19			agency staff received training and		
		as a NA that worked through			competencies before working in the		
		ent part of a neighboring			facility.		
		ed in other nursing facilities.			,		
	-	greed to come and in and			Effective 3/24/22, contact information f	or	
		came and picked her up and			the DON and Administrator will be post	ted	
	they arrived back at t	the facility around 10:30 PM.			at the nurses station in the event of nu	rse	
	NA #20 confirmed the	at she had never worked at			aide call outs or shortages and the DO	N	
	the facility before and	d was helping because Nurse			and/or Administrator will ensure trained	1,	
	1 ** *	end, and she did not want			competent nurse aide coverage is		
		NA #20 stated that when she			provided as required to meet resident		
	arrived at the facility,	-			needs.		
	_	that no residents on that					
	_	n touched because they did			Indicate how the facility plans to monito	or	
		ssigned staff members had			its performance to make sure that		
		rk. She stated she started			solutions are sustained:		
		ople on the assignment she			Director of Nursing and/or decigned wi		
		of those residents were rough to the bed which			Director of Nursing and/or designee wi audit 3 nurse aides weekly x 12 weeks		
	required a linen char				ensure they meet facility training and	ιο	
	required a liner onar	igo as well.			competencies.		
	An interview was cor	nducted with the SC on			competencies.		
	02/04/22 at 4:44 PM.	. The SC confirmed that the			Results of these audits will be reviewed	d at	
	facility had called her	r phone several times			monthly Quality Assurance Meeting for		
	through the night, bu	t she was not sure what they			further problem resolution if needed.		
	needed because she	was asleep and did not hear			Director of Nursing will review the resu	lts	
	her phone. The SC of	confirmed that NA #20 had			of weekly audits to ensure any issues		
	never worked at the	facility before and she did not			identified are corrected.		
		formation that all new					
		eceived when they came to			Completion date: 3/25/2022		
	-	vas also not sure which					
		ed for but stated she would					
	try and find out.						
	The interim Director	of Nursing (DON) and					
		nterviewed on 02/07/22 at					
		stated she knew nothing					
		d not know if she had ever					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		345128	B. WING			02/	23/2022
	PROVIDER OR SUPPLIER	VILLE		520	REET ADDRESS, CITY, STATE, ZIP CODE VALLEY STREET FATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	or not. The Administra about NA #20 and co a NA or not. All agend receive orientation the worked at the facility. staff were properly tradocumentation of that the facility. A follow up interview on 02/23/22 at 3:35 F worked for a local state the facility had a cont confirmed that she has facility prior to 02/03/2 facility since the end of A follow up interview Administrator on 02/2 Administrator confirmed to contract with the local worked for. Drug Regimen Review CFR(s): 483.45(c)(1) The drumst be reviewed at licensed pharmacist. §483.45(c)(2) This resident's mediangles worked for the resident's mediangles worked for the resident's mediangles with the pharmacist.	facilities in their corporation ator stated she knew nothing all ont confirm that she was by staff were expected to rough the SC before they. The expectation was that all ained with proper to training before working at training agency and stated that ract with them. She also ad never worked in the 22 and has not worked at the of her shift that day. Was conducted with the 13/22 at 5:26 PM. The led that the facility had a I staffing agency that NA #20 wy. Report Irregular, Act On (2)(4)(5) Immen Review. Up regimen of each resident least once a month by a size of the properties of		726			3/25/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 2/23/2022	
	ROVIDER OR SUPPLIER	ESVILLE		STREET ADDRESS, CITY, STATE 520 VALLEY STREET STATESVILLE, NC 28677	•	LI ZOI ZOZZ	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 756	drug that meets the (d) of this section f (ii) Any irregularitie during this review is separate, written reattending physician director and director and director and the irregularity (iii) The attending resident's medical irregularity has been to be no change in the physician should dithe resident's medical irregularity has been to change in the physician should dithe resident's medical irregularity has been to change in the physician should dithe resident's medical irregularity has been to change in the physician should dithe resident's medical irregularity in the process and stop when he or she iderequires urgent action in the process and stop	clude, but are not limited to, any e criteria set forth in paragraph for an unnecessary drug. It is noted by the pharmacist must be documented on a seport that is sent to the in and the facility's medical for of nursing and lists, at a dent's name, the relevant drug, or the pharmacist identified. So thysician must document in the record that the identified en reviewed and what, if any, ken to address it. If there is to be medication, the attending ocument his or her rationale in ical record. If acility must develop and and procedures for the monthly ew that include, but are not mes for the different steps in the pharmacist must take entifies an irregularity that the ion to protect the resident. Note in the pharmacist must take entifies an irregularity that the pharmacist must take entifies an irregularity that the protect the resident. Note in the pharmacist must take entifies an irregularity that the pharmacist must take entifies an irregularity that the protect the resident. Note in the paragraph of the paragraph of the pharmacist must take entifies an irregularity that the pharmacist must take entifies an irregularity that the pharmacist must take entifies an irregularity that the protect the resident. Note in the paragraph of the pharmacist must take entifies an irregularity that the pharmacist must take entified to pharmacist must take entified to pharmacist must develop and of ph	F	How corrective action accomplished for thos have been affected by practice; The facility failed to ha review that included ic missing and abnormal resident #1 during the December 2021 and J	e residents found to at the deficient ave a pharmacy dentification of I PT/INRs for months of January 2022.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			02	C 2/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE	,	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	10/21/21 and most re	ecently readmitted on	F7	756	completed by pharmacy consultant on		
	_	ses of atrial fibrillation and thrombosis of deep vein of			2/18/2022 and 3/7/2022 with no further irregularities noted. How the facility will identify other reside		
	dated 12/16/21, Resi	oital discharge summary dent #1 was to maintain a ange of 2.0 to 3.0 while on			having the potential to be affected by the same deficient practice; All current residents receiving Coumad will be reviewed by the pharmacy	ne	
	A Physician's order d PT/INRs were to be d anticoagulant usage.	ated 12/17/21 indicated daily obtained due to			consultant. This audit will be completed 3/14/2022. Address what measures will be put into	-	
		PT/INR laboratory results for 17/21 through 1/13/22 g:			place or systemic changes made to ensure that the deficient practice will no recur:	ot	
	of the 27 dates that F (12/17/21, 12/19/21, 12/28/21, 12/30/21, 1 1/9/22 through 1/11/2 There was no docum	/1/22 through 1/6/22, and (2) in the medical record. entation to indicate the ed and made aware these			Effective 2/7/2022 Regional Director of Clinical Services educated Director of Nursing and nurse management on reviewing pharmacy recommendations and residents on Coumadin to ensure irregularities were missed. This educat will be completed by 3/24/2022.	no	
	outside of the therape (12/24/21 - 6.32, 12/2 12/31/21 - 4.47, 1/7/2	PT/INR results that were eutic range of 2.0 to 3.0 25/21 - 3.29, 12/26/21 - 3.31, 22 - 5.24, and 1/8/22 - 4.59).			Effective 3/24/2022 newly hired facility agency Director of Nursing and/or nurs management will receive education durorientation and prior to working.	e ring	
	There was no documentation to indicate the Provider was notified of these PT/INR results which fell outside the provided parameters for Resident #1.				Facility to provide consultant pharmacicopy of PT/INR lab results for all reside receiving Coumadin therapy on a week basis for 3 months. Lab results will be uploaded, made readily accessible and	ents dy	
		e Practitioner wrote an order anged from being required y and Friday.			reviewable by Consultant pharmacist. Consultant pharmacist will review weel lab results as provided and identify any missing and/or abnormal PT/INRs as p	kly '	

	OF DEFICIENCIES CORRECTION	I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C	
NAME OF P	ROVIDER OR SUPPLIER	0.0.25	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	2/23/2022	
					520 VALLEY STREET			
ACCORD	US HEALTH AT STATE	SVILLE			STATESVILLE, NC 28677			
	CUMMADY	CTATEMENT OF DEFICIENCIES					0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From pa	ge 149	F	756				
	On 1/13/22 the Nurs	se Practitioner wrote an order			of an interim medication regimen revie	W.		
	for PT/INRs to be cl	nanged from being required			Consultant pharmacist will make any			
	daily to every Mond	ay and Friday.			recommendations for missing and/or			
					abnormal labs to the facility DON, NHA	١,		
		laboratory results ordered for			medical director and/or prescribing			
		ys for Resident #1 from 6/22 revealed the following:			physician.			
	1/13/22 tillough 1/2	0/22 revealed the following.			Indicate how the facility plans to monit	or		
	- There were no PT	/INR laboratory results for 4 of			its performance to make sure that	J1		
		INRs were ordered (1/14/22,			solutions are sustained:			
		nd 1/24/22) in the medical						
	record. There was r	no documentation to indicate			Director of Nursing and/or designee w	II		
		intacted and made aware			review pharmacy recommendations to			
	these labs were not	obtained.			ensure identification of irregularities wi	th		
	A	the Character and a supplementary			residents on Coumadin weekly x 12			
		onthly Pharmacy progress notes			weeks.			
		acy Consultant reviewed			Results of these audits will be reviewe	d at		
		cal record on 01/14/22 which			Quarterly Quality Assurance Meeting >			
	reflected the medica	al review from readmission on			for further problem resolution if needed			
	12/16/21 to 01/14/2	2 and read in part: Resident			Director of Nursing will review the resu	Its		
	**	with anemia and an abdominal			of weekly audits to ensure any issues			
		Coumadin therapy and to			identified are corrected.			
	reflected INR values 1/12/22 to be 2.98,	n goal. The note further s from 12/20/21 through 6.32, 4.4, 5.24, and 2.38 with			Completion date: 3/25/2022			
		ely and no reference to missing						
		o the ordered daily INRs and as suggested related to						
	Coumadin monitorir							
		statement provided by the						
		nt dated 2/7/22 regarding a						
		on 2/5/22 at 1:42 PM was						
		macy Consultant's statement						
		the Medical Record Review cist noted that Resident #1						
		adin. A review of his past						
		red that he had failed Eliquis.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245420		_			С
		345128	B. WING			02/	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	noted did also show to 3.5 was set due to while on Eliquis. This hyper-coagulable stawere reviewed and very that they had been dweek of 12/16/21: IN Week of 12/30/21: IN Week of 12/30/21: IN Week of 17/22: INR 1/12/22. The Pharma reviewed the results intervention by the preview yielded on 12 value of 4.4 which th Coumadin dosage as INR resulted in a val dosage was held from redrawn on 1/12 which was in a thera of 2.0-3.0. The Pharma written statement, the thought the medical appropriately which or recommendation regithat time. The writter part: "I agreed that if Physician's orders as concern", but in her of daily PT/INRs might in the long-term care say based on her clinonly be looking to se at least once weekly	cal record and progress on 12/1/21 that a goal of 3.0 opatient history of DVT failure is suggested a possible ate. The PT/INRs results were drawn routinely given drawn at least weekly being like was drawn on 12/20/21, and was drawn on 12/30/21, was drawn on 12/30/21, was drawn on 1/7/22 and acy Consultant indicated she of the INR values and rimary medical team. This is in it is well as on 1/7/22 when the we of 5.2 and the Coumadin in 1/7 through 1/11 and ich resulted in a value of 2.3 peutic range set on 12/16/21 macy Consultant wrote in her at based on her review, she team had intervened did not warrant a Pharmacy parding Coumadin therapy at a document further read in the facility did not follow is written, that was of clinical judgement "an order ght be considered excessive is setting". She elaborated to nical experience, she would be that PT/INRs were drawn	F	756			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			l	23/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	UZI	23/2022
ACCORDI	US HEALTH AT STATES\	/ILLE			ALLEY STREET ESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	during the December Each would expect th make appropriate rec during the medical red	ndations from the 's review for Resident #1 or January review periods. e Pharmacy Consultant to ommendations to the facility	F 7	756 757			3/25/22
SS=K		ary Drugs-General. regimen must be free from An unnecessary drug is any ssive dose (including					
	§483.45(d)(2) For exc §483.45(d)(3) Withou	essive duration; or t adequate monitoring; or					
		t adequate indications for its					
	§483.45(d)(5) In the process which reduced or discontinu	indicate the dose should be					
	stated in paragraphs section. This REQUIREMENT by: Based on record revi Practitioner (NP), and the facility failed to fol obtaining scheduled F	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced ew and staff, Nurse I Physician (MD) interviews, low physician's orders for Prothrombin Time Test/ ted Ratio (PT/INR), a test		ac ha	How corrective action will be ccomplished for those residents found ave been affected by the deficient ractice;	l to	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _				C / 23/2022
NAME OF P	ROVIDER OR SUPPLIER	0.0.20	1	STE	REET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022
NAME OF T	TO VIDER OR GOLT EIER						
ACCORDI	US HEALTH AT STATES	VILLE			VALLEY STREET		
				ST	ATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page	e 152	F 7	757			
	disorder or excessive (lab) studies. The fac medical provider of all outside the perimeter residents reviewed for (Resident #1) which rundergoing explorator removal of a very large. The immediate jeopa the facility failed to obe #1 for anticoagulant to physicians orders. The removed on 2/9/22 wimplemented a credit jeopardy removal. The compliance at a lower (a pattern of no actual more than minimal has	r unnecessary medications resulted in Resident #1 ry abdominal surgery and			The facility failed to follow a physician's order for obtaining scheduled PT/INR I and failing to notify the physician or nu practitioner when PT/INRs were not obtained. On 2/7/22, the MDS nurse updated Resident #1's anticoagulant therapy caplan to include monitoring for adverse side effects: discolored urine, black tar stools, sudden severe headache, N&V diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental stand/or vital signs, SOB or nose bleeds Care plan also includes notification to physician/nurse practitioner of all PT/IN results and of any adverse side effects anticoagulant drug use. How the facility will identify other reside having the potential to be affected by the standard of the protected of the protected in the protected of	abs rse rre ry atus . IR to	
	are effective. Findings included:	oring systems put into place			same deficient practice; Residents with scheduled PT/INR lab orders are at risk of labs not being		
	1. Resident #1 was a 10/21/21 with diagnos fibrillation (irregular hembolism and deep vof the lower extremity A hospital discharge sindicated Resident #1 hospital Intensive Caran abdominal wall he	summary dated 12/16/21			obtained as ordered and reported to the physician/nurse practitioner to ensure therapeutic levels are maintained. Therefore, effective 2/7/2022, the Inter Director of Nursing and licensed chargenurse reviewed current facility resident with orders for PT/INR labs to ensure lare being obtained as ordered by the physician/nurse practitioner. One additional resident was identified with PT/INR orders. Orders were reviewed PT/INRs were obtained as ordered.	im e s abs	
		eutic INR (abnormal higher			PT/INR flow record initiated, anticoagu care plan and MAR updated by the	lant	

Facility ID: 922999

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		V2/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)	
F 757	required 13 units of Discharge summary discharge, Resident been reversed and v (abnormally lower le bleeding) with a PT/I and Resident #1's w (an anticoagulant ble PT/INRs to be obtain parameters to be be the Computer Tomog and pelvis performed Department (ER) reviblood measuring 18: 15x18 cm. A review of a quarter dated 12/25/21 indic cognitively intact and include refusals of computer that the computer that it is admissible physician's order dated 12/25/21 indic cognitively intact and include refusals of computer that the computer that it is admissible physician's order dated 12/25/21 indices and include refusals of computer that the computer that the computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that the computer that it is physician's order dated 12/25/21 indices and include refusals of computer that the computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order dated 12/25/21 indices and include refusals of computer that it is a physician's order date	a from an active bleed which packed red blood cells. The also indicated upon #1's Coumadin dose had was currently subtherapeutic vel that decreases risk of INR level of 1.27 on 12/16/21 as ordered Coumadin 10 mg bod thinner) daily and hed daily with therapeutic tween 2.0 to 3.0. A review of graphy scan of the abdomen d in the Emergency realed 2 large collections of x22 centimeters (cm) and are with the series of existing the series of the series	F7	licensed nurse adverse side et physician/nurse results and adv follow-up interval Address what replace or system ensure that the recur: On 2/7/22, the Risk Managementhe Administrat Nursing, SDC (Coordinator) at Nurses on the on coumadin the PT/INR labs as corresponding sub/supratheral coumadin toxic drawing blood requisitions to reporting to nuroptions to obtain and reporting a Physician/Nurse On 3/24/22, Dillicensed Charteducation to fa nurses on lab provider if unal on the use of the current PT/INR lab results, next and results.	measures will be put into mic changes made to be deficient practice will not be deficient practice will not be deficient practice will not be deficient provided education of tor, Interim Director of (Staff Development and Licensed Charge lab process for residents therapy to include; obtain as ordered, the lab results, apeutic levels, signs of city, treatment for toxicity samples for PT/INRs, contracted lab provider a rse supervisor for alternatin the sample as ordered all lab results to the	lab of tot and to sing and totate and totat

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING_			,	C 2/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		212312022	
					VALLEY STREET			
ACCORDI	US HEALTH AT STAT	ESVILLE			ATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	Continued From p	age 154	F 7	757				
	12/19/21.	S .			maintain each resident therapeutic IN	R		
	1-7.1-21-11				range and reporting all results outside			
	No lab report was be obtained on 12	available for PT/INR ordered to //19/21.			parameters to the Physician/Nurse Practitioner			
	A lab report dated	12/20/21 indicated Resident			Effective 3/24/2022 all License Nurse			
		eutic PT/INR of 2.98.			including Agency staff before their firs			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				assignment, will be educated in	•		
	A physician's orde	er dated 12/20/21 indicated			orientation in person by Director of			
		o be administered Coumadin 8			Nursing and/or designee on facility lal	b		
	mg daily.				process for residents on coumadin			
					therapy. Reporting to medical provide	r if		
	A lab report dated had a therapeutic	12/21/21 indicated Resident #1 PT/INR of 2.7.			unable to obtain and education on the of the PT/INR flow records for current	t		
	No lob was and was	available for a DT/INID			PT/INR parameters, documenting lab			
	•	available for a PT/INR btained on 12/22/21 or			results, next lab draw date and currer and/or changing coumadin orders to	IL		
	12/23/21.	btained on 12/22/21 of			maintain each resident therapeutic IN	R		
	12/20/21.				range and reporting all results outside			
	The MAR revealed	d Resident #1's Coumadin 8 mg			parameters to the Physician/Nurse	, 01		
		on 12/20/21 through 12/23/21.			Practitioner			
	Δ nurse's note dat	ed 12/23/21 indicated a PT/INR			Indicate how the facility plans to moni	itor		
		due to lack of available			its performance to make sure that	toi		
		ply and upper management had			solutions are sustained:			
	been made aware							
					Effective 3/24/22, the Administrator or	r		
	A lab report dated	12/24/21 indicated Resident #1			Director of Nursing will monitor reside			
	had a critical PT/II	NR level of 6.32. There was no			with PT/INR orders to ensure complia			
		reflect notification of the			with obtaining, reporting and monitoring			
	physician or the n	urse practitioner.			as ordered. Audits will be completed times weekly x 12 weeks.	hree		
		d Resident #1's Coumadin 8 mg						
		on 12/24/21 despite			Results of these audits will be reviewed			
	supratherapeutic I	PI/INR.			Quarterly Quality Assurance Meeting			
		15 11 1 11 0 "			for further problem resolution if neede			
		d Resident #1's Coumadin was			Administrator will review the results o	ı		
		on 12/25/21. No orders were			weekly audits to ensure any issues			
	written for this held	u uuse.			identified are corrected.			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	, ,	COMPLETED		
		345128	B. WING			C 02/23/2022		
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	l	OL/LO/LOLL		
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F 757	Continued From pa	ge 155	F 75	57				
	•	2/25/21 indicated Resident #1 autic PT/INR of 3.29.		Completion date: 3/25/2022				
	'	2/26/21 indicated Resident #1 therapeutic PT/INR of 3.31.						
	A lab report dated 1 had a therapeutic P	2/27/21 indicated Resident #1 T/INR of 2.81.						
	No lab reports were 12/28/21.	available for the PT/INR on						
		Resident #1's Coumadin 8 mg n 12/26/21 through 12/29/21.						
	A nurses noted date may be obtained or	ed 12/28/21 revealed PT/INR n 12/29/21 per NP.						
	A lab report dated 1 level of 2.47.	2/29/21 indicated a PT/INR						
	No lab reports were 12/30/21.	available for the PT/INR on						
		dated 12/31/21 revealed be administered Coumadin 8						
		Resident #1's Coumadin 8 mg n 12/30/21 through 12/31/21.						
	#1's INR level was there was no docu	2/31/21 revealed Resident supratherapeutic at 4.47. mentation to reflect the practitioner were notified of the IR.						
	A physician's order	dated 12/31/21 indicated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	A review of all laborat through 12/31/21 revolutioned as ordered of the MAR indicated R receive Coumadin 7 r 1/7/22. No PT/INR lab report to 1/5/22. A provider progress in Resident #1's PT/INR and therefore the proland CBC. No lab reports were a PT/INR ordered on 1/2 had a supratherapeut There was no docum record to reflect the poland a supratherapeut There was no docum record to reflect the poland a supratherapeut There was no docum record to reflect the poland a supratherapeut There was no physici medical record to hold or to start the Coumal A nurses note dated was made aware on INR being supratheral	eceive Coumadin 7 mg daily. Fory data from 12/16/21 ealed PT/INRs were not on 6 days. Resident #1 continued to mg daily from 1/1/22 through It is were available from 1/1/22 Roted dated 1/6/22 revealed it was unable to be located vider ordered a stat PT/INR Revailable for the STAT	F	757			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 120 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	when chart review warealized the Coumad 1/8/22 and 1/9/22 alm No PT/INR lab report through 1/11/22. The MAR revealed Cadministered on 1/11 A PT/ INR lab report therapeutic level of 2 A physician's progress indicated PT/INR ord to every Monday and The MAR revealed Cadministered on 1/13 No PT/INR lab report or 1/17/22. An unscheduled PT/ indicated a therapeut The MAR revealed Cadministered on 1/20 No lab reports were a 1/24/22. A review of all laborathrough 1/24/22 reve obtained as ordered Cadministered on 1/20 A Situation, Background	sumadin dose for 1/10/22, but as conducted, the nurse in had already been held on eady se were available from 1/9/22 soumadin 7 mg was 1/22 and 1/12/22. dated 1/12/22 indicated a .38. se note dated 1/13/22 ers were changed from daily I Friday. soumadin 7 mg was 1/22-1/19/22. se were available for 1/14/22 INR lab report dated 1/19/22 cic level of 2.86. soumadin 7 mg was 1/22-1/26/22. available for 1/21/22 or tory data for 1/1/2022 aled PT/INRs were not on 13 days.	F	757			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345128	B. WING			02/	23/2022
NAME OF PR	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	HE HEALTH AT STATES	/II.E			520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES\	VILLE		;	STATESVILLE, NC 28677		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 757	Continued From page	e 158	F	757	7		
	revealed a change of	condition for bleeding (other					
	than GI) with instructions to send Resident #1 to the ER for an evaluation.						
		summary dated 1/28/22					
		arrived at the ER around					
	11PM on 1/26/22 for a	•					
		e oozing of blood. He was					
	·	atherapeutic PT/INR of 4.57					
		on Resident #1's right					
		d but began to bleed with					
		g to include a significant essure during initial attempts					
		me the ER physician felt this					
		life- threatening emergency,					
	-	to help control bleeding),					
		nt #1 to the hospital's ICU					
		t #1 was stabilized and					
	•	lity on 1/28/22 around 6 PM					
	with a subtherapeutic						
		summary dated 02/03/22					
		returning to the facility from					
	· ·	charge on 1/28/22, Resident					
		ack to the ER via EMS after					
		om his chair to the toilet at					
		a warm and wet sensation					
		ound himself to be bleeding					
		at had been sutured in the					
		of the Emergency Medical					
	Services (EMS), he w						
		bic centimeter/millimeter					
		en these findings and the ff to stop the bleeding from					
	•	dent #1 was re-admitted to					
	-	partment. Surgical services					
		29/22 and Resident #1					
		wall exploratory surgery.					
		minal surgery revealed a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022		
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02/20/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION		
F 757	centimeters (cm) in let 10 cm in depth. Approblood was evacuated An interview on 2/9/2 revealed she had wo the facility with reside 12/23/21 and stated slabs in the facility at the supplies such as tour Nurse #22 verbalized the outside contracted show up on the design scheduled, and staff had not shown up and draw labs on these downward and the order for PT/INR drawn on her not qualified to perform nursing supervisor with the distribution of the drawn and there anyone it needed to be an interview on 2/3/2 revealed he was an owner they did not all to perform venipunction trained on how to do indicated the order on the order of the order on the orde	ge hematoma which was 30 ength, 20 cm in width, and oximately 2600 cc of old I from the hematoma. 22 at 7:23 PM with Nurse #22 rked as an agency nurse at ent #1 on 12/22/21 and she was not able to draw imes due to the lack of rniquets and lab tubes. If there were also times when d lab company would not gnated days when they were did not always know they d therefore didn't know to ays. 22 at 2:53 PM with #1) revealed she worked the 1/22. She indicated she Resident #1 to have a reshift, but she knew she was rm the task and felt like the ould have known the lab was efore she did not notify	F 75	57			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP COD 520 VALLEY STREET STATESVILLE, NC 28677	_ E	02/25/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 757	#3 revealed she had not have supplies to chad been times when provider had not show were not made aware. An interview on 02/10 #21 revealed she had recalled times she had was unable to perform of supplies in the facil made nurse supervise. An interview on 02/10 #1 revealed she was she had been unable to lack of butterfly new Nurse #20 indicated in been made aware, but ongoing. An interview on 02/03 revealed facility staffed laboratory results to the Coumadin dosing for upon admission of 2-3 had to independently results system to locate being drawn. The NP orders not being follow multiple elevated PT/hospitalizations with esurgery. The NP indicated routinely, she	diracy ordered labs and there the outside contracted lab on up to draw labs, but staff the lab was not drawn. diracy ordered labs and there the outside contracted lab on up to draw labs, but staff the lab was not drawn. diracy at 1:35 PM with Nurse worked in the facility and directly worked at times when she in venipunctures due to lack ity. She indicated she had for aware. diracy at 1:45 PM with Nurse an agency nurse and stated to obtain labs at times due edles and blue lab tubes. The problem seemed to be directly at the problem seemed to be seed at 3:40 PM with the NP did not obtain and provide the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the set parameters provided at the providers to regulate the providers to regu	F	757		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		520	REET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET ATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	revealed she expected as ordered and if the provider did not obtain expected facility staff to the local contracted MD indicated a medic who should be made results or the inability seek further direction dosage or frequency MD stated she has has staff in the evening to believed it was the factontact the provider in required to manually explained copies of at the physician's contained and the physician's contained for the safe others on Coumadin receiving anticoagular monitored for adverse of the medication usate An interview on 02/08 Administrator and Interview on 02/08 Administrator and Interview on one of the medication usate therapy to include: for provider when labs and any lab results in an aresident's set perimes were expected to drain education and demonotobtaining labs.	deductions and side effects and side eff	F	757			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345128	B. WING			C
	ROVIDER OR SUPPLIER US HEALTH AT STATES			STREET ADDRESS, CITY, STATE, ZII 520 VALLEY STREET STATESVILLE, NC 28677	P CODE	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE
F 757	Continued From pag	ne 162	F 7	757		
	The facility provided	the following IJ removal plan.				
		residents who have suffered, serious adverse outcome ompliance:				
	obtaining scheduled	follow a physician's order for PT/INR labs and failing to or nurse practitioner when otained.				
	10/21/21 with diagrously and acute embolism unspecified deep verextremity. Physician anticoagulation there requires lab monitoring ranges of 2.0 -3.0. B 12/17/2021 - 1/24/20 physician orders for facility failed to obtain #1 based upon physician results for 6 days be 12/31/21 and 13 days between the dates of Additionally, Resided INR levels between 1/10/2022 with no nonurse practitioner. Shad a change in conrequired transfer to 1/26/22. Hospital reconstruction in the supplementary of the	in (DVT) of the lower orders included apy (Coumadin) which ing to ensure therapeutic setween the dates of 022, Resident #1 had PT/INRs to be obtained. The in PT/INRs labs for Resident ician orders with missing lab tween the dates of 12/17/21 - is of missing lab results f 1/1/22 - 1/24/22. In the dates of 12/24/21 - otification to physician or ubsequently, Resident #1 dition (bleeding) which he hospital for treatment on cords revealed Resident #1				
	had a ruptured abdo oozing of blood. He supratherapeutic PT the hospital. The res	minal hematoma with visible				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	ODE .	02/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE	
F 757	and discharged back around 6PM with a standard 1.28. Resident #1 rehospital on 1/28/202 abdominal area which procedure to evacua Resident #1 abdome. On 2/7/22, the MDS anticoagulant therap monitoring for adversurine, black tarry sto headache, N&V, diallethargy, bruising, sustatus and/or vital signification of any adverses drug use. PT/INR flot Resident #1 and mathe unit. Residents with schedat risk of labs not be reported to the physical ensure therapeutic letherapeutic l	Resident #1 was stabilized to the facility on 1/28/22 subtherapeutic PT/INR of quired transfer back to the 2 due to bleeding from the in turn required a surgical te a large hematoma from the incomplete and the incomplete a	F7	757		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345128	B. WING			C 02/23/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 520 VALLEY STREET STATESVILLE, NC 28677	P CODE	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 757	Continued From page	e 164	F 7	757		
	process or system fai adverse outcome fror when the action will b	entity will take to alter the lure to prevent a serious n occurring or recurring, and				
	Director of Regulatory Medical Director cond	Director of Operations, y and Risk Management and ducted an Ad Hoc QAPI ot cause analysis of the				
	facilities failure to mai obtaining labs as orde	intain a process for ered by the Physician/Nurse g to notify the physician or				
		education, lab process udits, and follow-up reviews				
	process of ensuring F ordered and that the I	e facility failed to have a PT/INR labs were drawn as icensed nurse was ing that blood samples are				
	collected as ordered i contracted lab provide failed to implement P	ncluding when not drawn by er and 2) licenses nurses T/INR procedure of notifying				
	were unable to be ob PT/INR levels were o for Resident #1. After	•				
	process, the facility of Nurses could verbaliz Charge Nurse when t	eason for not following lab concludes; a) while Licensed the process of notifying the unable to obtain a PT/INR as ot provide a reason for not				
	following the process Nurses could verbaliz the medical provider	and b) while Licensed te the process of notifying when PT/INR levels were ameters, they could not				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	1, ,	TE SURVEY MPLETED
		345128	B. WING			C 02/23/2022
	ROVIDER OR SUPPLIER	ESVILLE	'	STREET ADDRESS, CITY, STATE, 520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 757	On 2/7/22, the Dire Management provided in the case of the PT/III documenting lab recurrent and/or charge Nurse of the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider and recurrent and/or charmaintain each resider provider and recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting lab recurrent and/or charmaintain each resider provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III documenting all results Physician/Nurse Provider if unable to the use of the PT/III and Physician/Nurse Provider if unable to the use of the PT/III and Physician/Nurse Provider if unable to the use of the PT/III and P	ctor of Regulatory and Risk ded education to the im Director of Nursing, SDC to Coordinator) and Licensed the lab process for residents py to include; obtaining PT/INR expression of coumading to toxicity, drawing blood Rs, requisitions to contracted porting to nurse supervisor for toxicity to the sample as ordered to results to the reactitioner. Education also sibility of the licensed nurse to oles are collected as ordered drawn by contracted lab the licensed nurse to often alternate interventions to eand 3) reporting to medical to obtain and 4) education on	F	757		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	343120	B. W. C.	ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	23/2022
					0 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	SVILLE		Sī	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	levels, signs of count toxicity, drawing bloor requisitions to contrare reporting to nurse so to obtain the sample lab results to the Ph Education also includicensed nurse to encollected as ordered contracted lab provinurse communicates ordered to the Charginterventions to obtain reporting to medical and 4) education on records for current Edocumenting lab rescurrent and/or changmaintain each reside reporting all results Physician/Nurse Pra Nurse Aides were encounted and descenting including discolored sudden severe head joint pain, lethargy, I mental status and/or breath or nose bleed. The Director of Nursing Band Risk on 2/7/22. work until education	esults, sub/supratherapeutic madin toxicity, treatment for od samples for PT/INRs, acted lab provider and upervisor for alternate options as ordered and reporting all ysician/Nurse Practitioner. ded 1) responsibility of the sure blood samples are including when not drawn by der and that 2) the licensed in including when not drawn by der and that 2) the licensed in blood sample and 3) provider if unable to obtain the use of the PT/INR flow PT/INR parameters, bults, next lab draw date and ging coumadin orders to be entitle actioner. Effective 2/8/2022, ducated by the Director of eporting to Licensed Nurses fects of coumadin therapy urine, black tarry stools, lache, N&V, diarrhea, muscle or uising, sudden changes in the vital signs, shortness of	F	757			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _				C 23/2022
NAME OF PR	ROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE	1 021	23/2022
				Ę	520 VALLEY STREET		
ACCORDI	US HEALTH AT STATE	ESVILLE		•	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
F 757	Continued From pa	ge 167	F	757			
	day resident lab is ensure PT/INR labs documented on the PT/INR flow record physician/nurse prawill complete a lab the lab binder on the lab log all or order will be transcelectronic medical order on the Medic (MAR). Licensed Nedical record for orders. If PT/INRs Mondays, Wednes lab provider will oblicensed nurse is realternate dates or incontracted lab provinurse supervisor is ordered, the Physic notified, intervention implemented and crecord. The license results will report repractitioner and implicated. The individended in the lab Flow records will be provined to the provined to the lab flow records will be provined to the pr	e licensed nurse assigned the ordered to be drawn will are obtained as ordered, and all results reported to the actitioner. The licensed nurse requisition, place requisition in the nursing unit and document ders for PT/INRs. The lab ribed into the resident record which will display new action Administration Record urses will refer to electronic all new PT/INR physician order are to be drawn on days, or Fridays the contracted at an blood samples. The esponsible for obtaining on the absence of the dider. If the licensed nurse or unable to obtain lab draw as scian/Nurse Practitioner will be not and/or new orders occumented in the medical document new orders as widual resident PT/INR flow the licensed nurse and ab binder on the nursing unit.					
	management in clir monitor ongoing co initiated on 2/7/22 I Nursing for all Lice Licensed Nurses) of change in PT/INR I	nical morning meeting to impliance. Education was by the Interim Director of insed Nurses (including agency concerning this systemic ab process. The Director of a master employee list to track					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING _			1	C 23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		520 V	EET ADDRESS, CITY, STATE, ZIP CODE /ALLEY STREET TESVILLE, NC 28677	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	communicated to the Director of Regulator Licensed facility and receiving education of education completed included during orien. On 2/7/22, the Regio Services provided ed DON (Director of Nurmonitoring PT/INR flocilinical meeting to variordered and reported also included validati practitioner if INRs at therapeutic level to einterventions were for from serious side effe Administrators, DON receive education du Effective 2/7/22, the Nursing will monitor in to ensure compliance and monitoring as or completed five times Effective 2/7/2022, the Nursing will be ulti implementation of thi removal for this alleged Alleged Date of IJ Read A credible allegation medications was con 02/11/22. Record rev	Director of Nursing by the y and Risk on 2/7/22. agency licensed nurses not on 2/7/22 will not work until . Education will also be tation for newly hired staff. Inal Director of Clinical ucation to the Administrator, sing) and charge nurses on ow records during morning lidate labs are obtained as a to the physician. Education ing with the physician/nurse is not within the residents insure appropriate additional flowed to protect the resident ects. Newly hired is and charge nurses will ring orientation. Administrator or Director of residents with PT/INR orders is with obtaining, reporting, dered. Audits will be weekly. The Administrator and Director mately responsible to ensure is immediate jeopardy ed noncompliance.	F	757			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		PLETED
		345128	B. WING _		l	C / 23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760 SS=E	importance of followin obtaining PT/INR's ail values to the provided also provided education Coumadin therapy which included the fo PT/INR perimeters, we current Coumadin do to be drawn, as well a changes. The facility' was confirmed. Residents are Free of CFR(s): 483.45(f)(2) The facility must ensure §483.45(f)(2) Resident medication errors. This REQUIREMENT by: Based on record rev Practitioner (NP), and facility failed to admir orders for 2 of 2 sampland #17). 1. Resident #16 was 2/24/20 with diagnostic Resident #16 care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care played and 4/5/21 includes a samplant with the care play	s. Review included an all nurses to include the promptly. The in-service on on monitoring residents by utilizing PT/INR logs allowing for each resident: set when labs were drawn, sage, when the next lab was as any Coumadin dosage is IJ removal date of 2/9/22 af Significant Med Errors are that its-ints are free of any significant.	F 7		sulin per and notified effects t #17 will	3/25/22
	Resident #16 was to	ated 11/30/21 indicated receive Humalog Kwikpen n injector- give 10 units three		ordered. How the facility will identify other		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345128	B. WING			C 02/23/2022
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		02/20/2022
				520 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETION DATE
F 760	' '	e 170	F 76	60		
	times daily.			having the potential to be affect same deficient practice;	ed by the	
		ated 12/24/21 indicated				
		receive Lantus SoloStar 100		Effective 3/14/2022 the Director		
	u/mL (units/milliliter) units daily.	solution pen injector- give 30		Nursing and/or designee review residents insulin orders to ensu		
	units daily.			is administered per physician o		
	Review of Resident	‡16's physician orders				
	revealed there was no active order to check blood			Address what measures will be		
	sugar.			place or systemic changes mad		
	Δn Δnnual Minimum	Data Set (MDS) dated		ensure that the deficient practic recur:	e will not	
		esident #16 was cognitively		Teodi.		
	I .	days of insulin injections		Effective 3/24/2022 Director of	Nursing	
	during the reference	period.		and/or designee educated curre	-	
	The review of the Me	edication Administration		and agency Licensed Nurses o		
		nuary 2022 revealed no		insulin is administered per phys order. Education included medi		
	documentation that F			availability, ordering, reordering		
	administered her sch	eduled insulin on 6 days.		follow-up with pharmacy and ph		
		R, Resident #16 did not		medication is not available as o	rdered for	
	_	ikpen on 01/01/22, 01/02/22,		administration.		
	01/03/22 and 01/04/2	22. There was no e January MAR that Lantus		The licensed nurse will adminis	ter insulin	
		ered on 01/03/22, 01/05/22		as ordered by the physician. To		
	and 01/06/22.			medication availability, the licer	ised nurse	
				recieving order will transcribe o	-	
		8/22 at 11:40 AM with Nurse		receipt from physician into the E		
		ked with Resident #16 on 22 and did not administer the		Medical Record (EMR)for phare The licensed nurse receiving m	-	
		Resident #16 because the		from pharmacy will promptly sto		
	insulin was not availa			medication on the medication c		
				resident. Refills requests will be		
		/22 at 1:35 PM with Nurse		the licensed nurse within three	•	
		rked with Resident #16 on administer the scheduled		completion of current medication ensure delivery of refill for admit		
		16 because the insulin was		as ordered. If medication is not		
	not available.	. C 2234455 the mount was		for administration as ordered, the		
				nurse will notify the physician a		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		OLI ESI ESEE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	Nurse #23 was assigned on 1/04/22 and was uninterview. An interview on 02/0 Nurse Practitioner reinsulin placed Residerisk and was a signification of the provision of the prov	gned to Resident #16 on nable to be reached for an 03/22 at 3:40 PM with the evealed not receiving ordered ent #16 at increased health ficant medication error.	F 7	follow-up as advised. Effective 3/24/2022 any facility: agency Licensed Nurses that habeen educated will not be allow until receive education in-person telephone by Director of Nursing designee. Effective 3/24/2022 newly hired and agency Licensed nurses wite education during orientation and working. Indicate how the facility plans to its performance to make sure the solutions are sustained: Director of Nursing and/or design audit 3 residents insulin orders it is available and administered physician order 3x a week x 4 which week x 4 weeks and weekly x 1. Results of these audits will be requarterly Quality Assurance Meters for further problem resolution if Director of Nursing will review the forweakly audits to ensure any its identified are corrected. Completion date: 3/25/2022	as not ed to work on or via g and/or facility ill receive d prior to o monitor nat gnee will to ensure per veeks, 2x a 2 weeks. eviewed at eeting X 3 needed. he results	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 02/23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 760	Resident #17 was not Insulin-Glargine-yfgr following dates 01/05. The MAR also indicated sugars fluctuated be no recent A1C's available from phase of the management of the ma	anuary 2022 documented of administered a 27 units as ordered on the 5/22, 01/06/22 and 01/07/22. Atted Resident #17's blood tween 119-263 and she had alable on the chart. Attending the sident #17 on and 01/07/22 and did not led insulin due to it being armacy and did not locate the exactup supply. Attending the sident #17 on and 01/07/22 and did not locate the exactup supply. Attending the sident #18 and dication error. By 22 at 3:40 PM with the Nurse at increased health risk and dication error. By 22 at 5:30 PM with the she expected all residents to as ordered. By 22 at 12:21 PM with the terim Director of Nursing	F 70	60	
F 761 SS=E	administered as order receive insulin shoul effects. Label/Store Drugs at CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biological	of Drugs and Biologicals s used in the facility must be with currently accepted	F 70	51	3/25/22

PRINTED: 03/24/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			02/3	23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET TATESVILLE, NC 28677	1 02/1	25/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	§483.45(h)(1) In according Federal laws, the facibiologicals in locked of temperature controls, personnel to have according for the Comprehensive Experience of the Comprehensive Experience o	y and cautionary expiration date when a spiration date with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. Stility must provide separately affixed compartments for drugs listed in Schedule II of the drugs subject to the facility uses single unit tion systems in which the simal and a missing dose can a single in a single date of the medication rooms reviewed ation room) and the facility the counter medications ge for 2 of 4 medication all (COVID) and 100 hall the 200 hall back medication on 02/03/22 at 2:47 PM with	F	761	How corrective action will be accomplished for those residents found have been affected by the deficient practice; The facility failed to store controlled substances in a permanently affixed compartment of the refrigerator under double lock and key. Controlled substances permanently affixed to refrigerator on 3/9/2022. The facility failed to store over the cour medications in their original package. Improperly packaged medications were disposed of on 3/7/22.	nter		

				TE SURVEY MPLETED		
		345128	B. WING		0.	C 2/23/2022
NAME OF PE	ROVIDER OR SUPPLIER	0.0120	1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	2/23/2022
TVAINE OF T	NOVIDER OR OUT FEER			520 VALLEY STREET	•	
ACCORDI	US HEALTH AT STATE	SVILLE		STATESVILLE, NC 28677		
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(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From pa	ge 174	F 7	61		
	the following: loraze milligrams (mg)/1 n lorazepam 2 mg/ml controlled substand refrigerator not in a Nurse #10 was inte PM. Nurse #10 stat refrigerator should	epam (controlled substance) 2 nilliliter (ml) 4 vials and 1 bottle of 30 ml. The tes were lying in the the secured compartment. erviewed on 02/03/22 at 2:53 ted that the medication thave been locked because all tes needed to be secured		How the facility will identify oth having the potential to be affect same deficient practice; Effective 3/14/2022 all medicates were reviewed by the Director (DON) to ensure controlled surface are permanently affixed to refrese	tion rooms of Nursing bstance box	
	took the lorazepam medication room th compartment that v	Nurse #10 stated that she and put it in the other at had a permanently affixed was under double lock and where to find the medication if		under double lock and key. No concerns identified. Effective 3/14/2022 over the comedications were reviewed by ensure proper packaging and Improperly stored medication to	o additional ounter or the DON to storage.	
	interviewed on 02/0 stated that controlled	Director of Nursing (DON) was on 02/07/22 at 3:40 PM. The DON controlled substances should be kept le lock in a permanently affixed locked		not in original package were d Address what measures will be place or systemic changes ma ensure that the deficient practice.	e put into ade to	
	that had over the counter medications written were: 16 Colace ca 2 Aspirin tablets, 14 tablets and 8 Vitam An interview with N AM revealed the nucounter medication carts because som of over the counter acknowledged that	all (COVID) medication cart counter medications stored in cups with the names of the cups. The medications apsules, 23 Senna plus tablets, 4 Aspirin 81 tablets, 7 Zinc 220 ain C tablets. urse #16 on 02/02/22 at 6:00 arses will borrow over the s from the other medication etimes the facility will run out medications. The Nurse nurses should not be pouring ontainers that were not		Effective 3/24/2022 Director of and/or designee will educate of facility and agency License Nu Medication Aides on controlled box being permanently affixed refrigerator and over the count medications being kept in its of package. The Unit Coordinato monitor medication storage rocarts at least weekly for prope Newly hired facility and agency nurses and medication aides we ducation during orientation all working.	current urses and d substance to ter original rs will oms and r storage. y licensed will receive	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	SVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 761	b. On 02/02/22 at 6: made of the 100 Ha had an unlabeled plawhite oblong pills in An interview was co 02/02/22 at 6:25 AM when the facility ran counter medications medications from an medication room was acknowledged that to pouring medications During an interview 02/04/22 at 10:18 Al in charge of the centook over the resport the counter medication to was still very mucontinued to explain nurses to make a liscounter medications medications were in put in the medication	d by the manufacture. 25 AM an observation was all (Front) medication cart that eastic medication cup with 10 the cups. Inducted with Nurse #8 on all. The Nurse explained that out of stocked over the other cart until the serestocked. The Nurse he nurses should not be from unidentified containers. With the Supply Clerk on all the straightful of ordering the over ions a couple of months ago inch learning how to do it. She that she asked a couple of the needed over the and ordered them and the her office and ready to be in rooms. An observation of	F 76		will ently punter ge ved at for	
	A follow up interview 02/04/22 at 12:25 Pl with the over the coudelayed for two wee medications were or Supply Clerk stated over the counter me because she could a	wer the counter medications of in the Supply Clerk's office. with the Supply Clerk on M revealed the delivery truck unter medications was ks and some of the of back order. Regardless, the there was no reason for the dications to run out of stock always order the medications armacy and could go to the				

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	acting Director of Nur 3:40 PM the DON exple any reason why the run out of medication medications because to the local pharmacy medications until the The Administrator stathat there would be eeach of the medication Nutritive Value/Appear CFR(s): 483.60(d)(1) [S483.60(d) Food and Each resident received \$483.60(d)(1) Food pronserve nutritive value \$483.60(d)(2) Food and Each resident received \$483.60(d)(2) Food and Each	ith the Administrator and sing (DON) on 02/07/22 at plained that there should not be medication rooms would be especially over the counter the Supply Clerk could go and purchase enough regular supply order arrived. It that her expectation was anough medications to supply in carts. In Palatable/Prefer Temp (2) drink is and the facility provides- repared by methods that ue, flavor, and appearance; and drink that is palatable, fe and appetizing is not met as evidenced ans, test tray, resident, and appearance, taste, and 4 residents reviewed desident #6 and Resident	F 8	How corrective action will be accomplished for those residents four have been affected by the deficient practice; The facility failed to serve palatable for that was appetizing in appearance, ta and temperature for resident #6 and resident #10. How the facility will identify other resident	ood ste,	3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45400	D WING				С	
		345128	B. WING _				02/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT STAT	FSVII I F		520 \	ALLEY STREET			
ACCONDI	OO HEAEIII AI OIAI	LOVILLE		STA	TESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 804	Continued From page	age 177	F 8	304				
		his time. The menu for the biscuits with gravy, scrambled		- 1	naving the potential to be affected same deficient practice;	by the		
	eggs, and oatmeal conducted with Co The test tray was p kitchen at 8:24 AM	Date date at 8:22 AM and left the land arrived at the unit at 8:25		E	Effective 3/14/2022 the Dietary Ma and Administrator completed a test ensure food is appetizing in appea aste, and temperature and it was.	t tray t rance	to	
	AM. The test tray was sampled on 02/02/22 at 9:05 AM after the last of the breakfast trays on the hall had been served. The Dietary Manager was present when the lid of the test tray was removed. There was no visible steam noted when the lid was lifted, and the hot plate was also cool to			p e r	Address what measures will be pur- place or systemic changes made to ensure that the deficient practice we ecur: Effective 3/24/2022 Dietary Manag designee educated dietary staff on	o vill not ger or	:	
	touch. A pat of but bowl and slowly be egg and gravy bise not room temperat was dark brown al chew through. The with no sweetness the test tray. Wher	ter was placed in the oatmeal egan to melt. The scrambled cuit were tasted and were cool, ure. The bottom of the biscuit most black and was tough to e oatmeal was warm but bland noted. The DM did not taste in asked about why the ere cool not even warm		e tu b N p	pensuring meals are palatable and appetizing in appearance, taste, are emperature. Newly hired dietary so be educated during orientation by I Manager on ensuring meals served palatable. The Dietary Manager with complete test trays weekly to ensure compliance.	nd staff wi Dietar d are		
	temperature, she shard to keep the followed to help them be resident immediate the hallway. She e	stated that they worked very bod warm, but the nursing staff by passing the trays out to the ely when they delivered them to xplained when they sit on the ets cold even with the hot plate,		it s # to v	ndicate how the facility plans to mean to performance to make sure that solutions are sustained: Administrator and/or designee will est tray twice weekly x 4 weeks, the veekly for 8 weeks to ensure food	audit hen		
	3:40 PM. The Adm expected the food palatable and serv texture. She added at the facility so sh	was interviewed on 02/07/22 at inistrator stated that she served to the residents to be ed at the right temperature and d she had never tried the food e could not attest to the taste any of the food due to her diet.		F n fi	palatability. Results of these audits will be revieus anonthly Quality Assurance Meeting urther problem resolution if needed administrator will review the results weekly audits to ensure any issues dentified are corrected.	g for d. s of	at	

AND PLAN OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3	O DATE SURVEY COMPLETED
		345128	B. WING			C 02/23/2022
	OVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	.	02/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	to be served to the reat the unit, so the foot to enjoy. 2a. Resident #10 wa 03/01/05. Review of the quarted dated 01/09/22 indiccognitively intact. An observation and it with Resident #10 or Resident #10 was up beside her bed. Her her bedside table. The had a biscuit covered and a small bowl of two of the biscuit gor remained untouched her breakfast was cogood but "I ate what 2b. Resident #6 was 01/05/22. Review of the admis (MDS) dated 01/13/2 was cognitively intact a biscuit with gravy, breakfast that day. Hecold cold" it tasted a	ated she expected the food esident as soon as it arrived od was hot for the residents as readmitted to the facility on erly Minimum Data Set (MDS) ated that Resident #10 was attentive were conducted to 02/02/22 at 9:24 AM. To in her wheelchair sitting breakfast tray remained on the tray contained a plate that in gravy, scrambled eggs, beatmeal. There was a bite or the and the rest of the tray in Resident #10 stated that old and did not taste very it could." admitted to the facility on sion Minimum Data Set 22 revealed that Resident #6	F 80	Completion date: 3/25/2022		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING			l	C 23/2022
	ROVIDER OR SUPPLIER	VILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	more waiting on the sex Resident #6 stated the time to bring us our tresomething up for us, and get served which is useful but never hot. Cook #1 was interviewed took #1 stated that see day just before they seen sure that the food wappropriate temperatives certain that where was warm but added on the hallway a bit between." The Dietary Manager 02/02/22 at 9:05 AM. the food trays left the was hot, but the trays while before getting sethe food gets cold. The	it sat there for 30 minutes or staff to deliver it to us. e staff barely had enough ay let alone go and heat so I just make do with what I sually room temperature or wed on 02/02/22 at 8:32 AM. he temped the food each started plating the meal to	F	804			
F 806 SS=D	CFR(s): 483.60(d)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	references, Substitutes (5) drink	F	806			3/25/22
	§483.60(d)(4) Food the allergies, intolerances §483.60(d)(5) Appeal nutritive value to resident	•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	•	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 806	Continued From page		F8	06			
	by: Based on observation and staff interview the requested food prefermeal for 1 of 3 resided (Resident #8). The findings included Resident #8 was admo2/02/21. Review of the annual dated 01/01/22 reveat cognitively intact. An observation and in with Resident #8 was sittlinher bed and had her that appeared to have tray. Resident #8 staff she ordered and explant circle what she with a taken her ord morning's breakfast rordered bacon, grits, juice to drink. She explained that she differench toast sticks we Resident #8 stated the states of the	In is not met as evidenced on, record review, resident, the facility failed to provide the rences for the breakfast onts reviewed for preferences on the facility of the facil		How corrective action will be accomplished for those resider have been affected by the defic practice; The facility failed to provide the food preferences for resident # 3/7/22 Dietary Manager provide reeducation to dietary cook on food as indicated on resident medicated on resident medicated on resident medicated to be affect same deficient practice; On 3/14/2022 Dietary Manager designee completed a tray line observation during lunch to enstray are properly plated accord resident meal tickets. All meals according to meal ticket and repreference. Address what measures will be place or systemic changes made ensure that the deficient practic recur: Effective 3/24/2022 Dietary Madesignee educated dietary staff ensuring resident receives what ordered and indicated on meal dietary staff are responsible for reviewing meal tickets and meaning meaning meal tickets and meaning meaning meal tickets and meaning meaning mealigements.	e requested 8. On ed 1:1 plating heal tickets. er residents ted by the r and/or sure meal ing to s plated sident e put into de to ce will not unager or f on at is ticket. The r accurately		
		ewed on 02/04/22 at 10:23 ned that she had taken		ensure accuracy before sendin residents. Newly hired dietary s	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345128	B. WING _			02/	23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
A C C O D D I	US HEALTH AT STATES	val e		5	20 VALLEY STREET		
ACCORDI	US REALIN AL STATES	VILLE		5	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 806	Continued From page	e 181	F 8	306			
	Resident #8's breakfa	ast order for 02/04/22. She			educated during orientation by Dietary		
		#8 had ordered grits, bacon,			Manager on ensuring resident received		
		anted orange juice to drink.			what was requested on meal ticket.		
		had circled the items on the			·		
	menu and placed it ba	ack on Resident #8's meal			Effective 3/24/2022 Director of Nursing	or	
	tray to go back to the	kitchen so the kitchen staff			designee will enhanced the education	io	
	knew what she wante	ed to eat at breakfast on			facility and agency certified nursing		
	02/04/22.				assistants on ensuring when residents		
					out the choice menu it is sent back on	the	
		(DM) was interviewed on			meal tray to the kitchen or turned into		
		The DM stated she could			Dietary Manager mailbox.		
		pened to Resident #8's e stated that the kitchen			Indicate how the facility plans to monitor	or.	
		hey served her what was on			its performance to make sure that	וו	
		e DM stated that something		solutions are sustained:			
	_	u between the hallway and					
		ed to the kitchen but added			Administrator and/or designee will audi	it 3	
	_	vith Resident #8 so she			resident trays 3x weekly x 4 weeks,		
	could get what she w	anted for lunch and dinner.			weekly x 4 weeks, bi-weekly x 4 weeks	to l	
	The DM explained that	at the process was the			ensure accuracy of food received per		
		ng day would go out on the ither the resident or the			meal ticket.		
	•	rcle what the resident			Results of these audits will be reviewed	d at	
	wanted and then plac	e the menu back on the tray			monthly Quality Assurance Meeting fo	r	
		kitchen. Once in the kitchen			further problem resolution if needed.		
		t the resident requested and			Administrator will review the results of		
		be plated and served to the			weekly audits to ensure any issues		
		OM could not explain what			identified are corrected.		
		t #8's menu but stated			0		
		would have been served			Completion date: 3/25/2022		
	what was on the regu	iich was french toast sticks,					
	sausage, and oatmea						
		s interviewed on 02/07/22 at					
		strator stated that she					
		ne that was able to decide					
	what they wanted to					ĺ	
	opportunity to do so a	and the nursing staff would					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER	SVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		1 02/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 806	Administrator added	re 182 return it to the kitchen. The then she expected the what the resident requested.	F 80	06		
F 807 SS=E	CFR(s): 483.60(d)(6) §483.60(d) Food and Each resident receiv §483.60(d)(6) Drinks liquids consistent with preferences and suffinydration. This REQUIREMEN by: Based on observation interviews the facility water for 5 of 5 reside preferences (Reside) The finding included 1. Resident #2 was 02/02/21. The quarterly Minimulated 11/24/21 reveal cognitively intact. During an observation Resident #2 on 02/0 pointed to a Styrofoa approximately one for explained that the falice water. He continued	d drink es and the facility provides- is, including water and other th resident needs and ficient to maintain resident T is not met as evidenced ons, record reviews and of failed to provide fresh ice lents reviewed for fluid int #2, #5, #12, #13 and #19). Exact admitted to the facility on Jum Data Set assessment aled Resident #2 was on and interview with 2/22 at 3:10 PM the Resident	F 80	How corrective action will be accomplished for those residents for have been affected by the deficient practice; The facility failed to provide fresh it water for resident #2, resident #5, #12, resident #13 and resident #19 Fresh ice water was made available resident #2, resident #5, resident #1 and resident #19 on 2 and daily thereafter. How the facility will identify other reshaving the potential to be affected same deficient practice; Effective 3/14/2022 the Director of Nursing and/or designee assessed current residents to ensure fresh ware available at bedside and within Fresh ice water provided as neede	t ce resident o. de to et ce to esidents by the etc etc etc etc etc etc etc etc etc et	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/23/2022
				520 VALLEY STREET	
ACCORDI	US HEALTH AT STATES\	/ILLE		STATESVILLE, NC 28677	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 807	Continued From page	e 183	F 80	07	
	During an interview o	n 02/02/22 at 6:40 AM		Address what measures will be p	ut into
	•	xplained they passed out		place or systemic changes made	
	fresh ice water twice			ensure that the deficient practice recur:	
	On 02/02/22 at 8:25 A	AM an interview was			
	conducted with Nurse	#11 who explained that ice		Effective 3/24/2022 Director of Nu	ırsing
		t once a shift on third shift.		and/or designee educated curren	:
				Certified Nursing Assistants and I	icense.
	On 02/03/22 at 3:15 F			Nurses on ensuring residents have	
		#2 who stated he worked		water available at bedside and wi	
		PM. The Nurse explained		reach. Certified Nursing Assistant	
	-	ass out fresh ice water on a		responsible for passing ice water	
		he gave extra fluids when		shift and as requested by the resi	dent to
	he gave the residents	their medications.		ensure proper hydration.	
	On 02/05/22 at 10:40	AM an interview was		Effective 3/24/2022 any Certified	Nursing
	conducted with Nurse	Aide (NA) #15 who stated		Assistances and License Nurses	
	she worked 7:00 PM	to 7:00 AM. The NA		not been educated will not be allo	wed to
		ce water was passed out		work until receive education in- pe	
		cluded changing out the ice		via telephone by Director of Nursi	ng
	cup every day as well	l.		and/or designee.	
	On 02/05/22 at 11:45			Effective 3/24/2022 all Certified N	
	conducted with Nurse	, ,		Assistances and License Nurses	<u> </u>
		ce water was passed out		Agency staff before their first assi	_
		ce cups were changed out		will be educated in orientation in p	
	every day on third shi	π.		by Director of Nursing and/or des	-
	On 02/05/22 at 12:20	DM on intension was		"ensuring residents have fresh wa	
	On 02/05/22 at 12:20	Aide (NA) #16 who worked		available at bedside and within re	au1.
		s. The NA explained that		Indicate how the facility plans to r	nonitor
		assed out once a shift and		its performance to make sure that	
	•	anged out on third shift.		solutions are sustained:	
	An interview was con-	ducted with Nurse #4 on		Director of Nursing and/or design	ee will
		. The Nurse explained that		audit 3 residents to ensure fresh	
		AM to 7:00 PM and fresh		available at the bedside and withi	
		assed out at the beginning		3 X week X 4 weeks, weekly X 4	
		ift. The Nurse stated the		and bi-weekly X 4 weeks.	,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			1	C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	LUIZUZZ
				5	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		S	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 807	Continued From page	e 184	F 8	307			
F 807	Styrofoam cups shou third shift. An interview was con #17 on 02/10/22 at 12 that he worked first at passed out fresh ice with checked at 10:00 AM resident needed more ice chest stayed on the residents requested. 2. Resident #5 was at 04/14/16. The quarterly Minimu dated 10/24/21 reveat cognitively intact. During an observation Resident #5 on 02/03 Resident explained the Resident Council voice residents were not rethe staff got better at every shift. The Resident and pointed to an em 01/29/22. The Resident that he had to ask for did not believe he showater. During an observation Resident #5 on 02/03	ducted with Nurse Aide (NA) 2:10 PM. The NA explained and second shift and he water in the mornings and and after lunch to see if the e water. The NA stated the he hall for easy access when hed more water. dmitted to the facility on m Data Set assessment led Resident #5 was n and interview with he/22 at 10:40 AM the hat a few months ago the hed concerns that the he ceiving fresh ice water hent continued to explain hot give them fresh ice water hent stated the staff told him he fresh ice water and he he held have to ask for fresh ice	F 8	307	Results of these audits will be reviewed monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the result of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022		
		n 02/02/22 at 6:40 AM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		02	C 2/23/2022
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	, 02	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 807	Continued From page Nurse Aide (NA) #3 e	e 185 xplained they passed out	F 80	07		
	water was passed ou On 02/03/22 at 3:15 fconducted with Nurse from 7:00 AM to 7:00 that the staff did not proutine basis and that he gave the residents During an observation Resident #5 on 02/04 PM the Resident poin have fresh ice water a 01/29/22. On 02/05/22 at 10:40 conducted with Nurse	AM an interview was a #11 who explained that ice tonce a shift on third shift. PM an interview was a #2 who stated he worked PM. The Nurse explained wass out fresh ice water on a state he gave extra fluids when a their medications. In and interview with 1/22 at 9:30 AM and 12:15 with a state out that he still did not and the cup was dated AM an interview was a Aide (NA) #15 who stated				
	every day and that incup every day as well On 02/05/22 at 11:45 conducted with Nurse explained that fresh iconce a shift and the icevery day on third sh On 02/05/22 at 12:20 conducted with Nurse first and second shifts fresh ice water was p	ce water was passed out cluded changing out the ice l. AM an interview was a Aide (NA) #7 who be water was passed out be cups were changed out				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	VILLE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 807	Continued From pag		F 8	307		
	02/10/22 at 12:00 PM she worked from 7:0 ice water should be p and the end of the sh	nducted with Nurse #4 on M. The Nurse explained that O AM to 7:00 PM and fresh passed out at the beginning hift. The Nurse stated the all be changed every day on				
	#17 on 02/10/22 at 1 that he worked first a passed out fresh ice checked at 10:00 AM resident needed mor	nducted with Nurse Aide (NA) 2:10 PM. The NA explained and second shift and he water in the mornings and I and after lunch to see if the e water. The NA stated the he hall for easy access when ted more water.				
	3. Resident #12 was 09/12/21.	admitted to the facility on				
		ım Data Set assessment aled Resident #12 was				
	_	on 02/02/22 at 6:40 AM explained they passed out a shift on third shift.				
		AM an interview was e #11 who explained that ice it once a shift on third shift.				
	Resident explained t fresh ice water on a him empty Styrofoan Resident continued t	n and interview with 03/22 at 11:00 AM the hat the staff did not pass out routine basis and pointed to a cup dated 01/29/22. The o explain that he was able to room and would get a drink				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			02/2	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, 520 VALLEY STREET STATESVILLE, NC 28	,	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 807	During an observation Resident #12 on 02/0 Resident pointed out fresh ice water. On 02/03/22 at 3:15 Fronducted with Nurse from 7:00 AM to 7:00 that the staff did not proutine basis and that he gave the residents. During an observation Resident #12 on 02/0 PM the Resident point have fresh ice water a 01/29/22. On 02/05/22 at 10:40 conducted with Nurse she worked 7:00 PM explained that fresh ice very day and that incup every day as wellon 02/05/22 at 11:45 conducted with Nurse explained that fresh ice very day as wellon 02/05/22 at 11:45 conducted with Nurse explained that fresh ice	and interview with 3/22 at 2:45 PM the that he still did not have PM an interview was #2 who stated he worked PM. The Nurse explained was out fresh ice water on a he gave extra fluids when their medications. In and interview with 4/22 at 9:30 AM and 12:15 ted out that he still did not and the cup was dated AM an interview was Aide (NA) #15 who stated to 7:00 AM. The NA water was passed out cluded changing out the ice. AM an interview was Aide (NA) #7 who was water was passed out was earlier (NA) #7 who was water was passed out was earlier (NA) #7 who was water was passed out was cups were changed out fit.	F	307	DEFICIENCY)		
	conducted with Nurse first and second shifts fresh ice water was p	e Aide (NA) #16 who worked s. The NA explained that assed out once a shift and anged out on third shift.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	D BE COMPLETION	
F 807	02/10/22 at 12:00 PN she worked from 7:00 ice water should be pand the end of the sh Styrofoam cups shouthird shift. An interview was con #17 on 02/10/22 at 1 that he worked first a passed out fresh ice checked at 10:00 AM resident needed morice chest stayed on tithe residents request 4. Resident #13 was 07/16/16. The annual Minimum 12/19/21 revealed Reintact. During an interview of Nurse Aide (NA) #3 efresh ice water twice on 02/02/22 at 8:25 conducted with Nurse water was passed out 0n 02/03/22 at 3:15 conducted with Nurse from 7:00 AM to 7:00 7:	ducted with Nurse #4 on I. The Nurse explained that I. AM to 7:00 PM and fresh bassed out at the beginning lift. The Nurse stated the lid be changed every day on I. The Nurse stated the lid be changed every day on I. The Nurse stated the lid be changed every day on I. The Nurse Aide (NA) I. The NA explained and second shift and he lid and after lunch to see if the lid ewater. The NA stated the lid he hall for easy access when lid had after lunch to see if the lid had after lunch to see if the lid water in the mornings and I. The NA explained I. The NA explained that ice I. The Na explained tha	F 80	77		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 2/23/2022
	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		2/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 807	cup in her room. The not brought her fresh During an observation Resident #13 on 02/0 Resident did not have and stated they still h water yet today. On 02/05/22 at 10:40 conducted with Nurse she worked 7:00 PM explained that fresh in every day and that incup every day as wel On 02/05/22 at 11:45 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at 12:20 conducted with Nurse explained that fresh in once a shift and the inevery day on third shift on 02/05/22 at	n and interview with 14/22 at 9:20 AM the 25 fresh ice water or water Resident stated they have water yet. In and interview with 14/22 at 5:15 PM the 25 fresh water at her bedside ave not brought her fresh AM an interview was 25 Aide (NA) #15 who stated to 7:00 AM. The NA 26 water was passed out cluded changing out the ice I. AM an interview was 26 Aide (NA) #7 who 26 water was passed out 27 ce water was passed out 28 Ce water was passed out 29 ce water was passed out 29 ce cups were changed out	F 8			
	An interview was con 02/10/22 at 12:00 PM she worked from 7:00 ice water should be p and the end of the sh	assed out once a shift and anged out on third shift. ducted with Nurse #4 on I. The Nurse explained that O AM to 7:00 PM and fresh assed out at the beginning ift. The Nurse stated the ld be changed every day on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE	•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 807	#17 on 02/10/22 at 12: that he worked first a passed out fresh ice checked at 10:00 AM resident needed more ice chest stayed on the the residents request 5. Resident #19 was 10/14/21. The admission Minimal dated 10/19/21 reveal cognitively intact. During an interview of Nurse Aide (NA) #3 of fresh ice water twice On 02/02/22 at 8:25 of conducted with Nurse water was passed out During an observation Resident #19 on 02/07 Resident explained the Resident Council meaup that they were not Resident continued to better for a while about water every shift but facility and the facility they were back to no routine basis. The Redays without fresh ice pointed to an undated about half full of water and the stayers and the facility of water about half full of water and the facility of water about half full of water and the stayers are the stayers and the facility they were back to not routine basis. The Redays without fresh ice pointed to an undated about half full of water and the stayers are the stayers are the stayers are the stayers and the stayers are the	ducted with Nurse Aide (NA) 2:10 PM. The NA explained and second shift and he water in the mornings and and after lunch to see if the e water. The NA stated the he hall for easy access when ded more water. admitted to the facility on aum Data Set assessment heled Resident #19 was an 02/02/22 at 6:40 AM explained they passed out a shift on third shift. AM an interview was e #11 who explained that ice at once a shift on third shift.	F	807			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIF 520 VALLEY STREET STATESVILLE, NC 28677	CODE	OL/LG/LGLL
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE
F 807	been a month since Styrofoam cup. Obsono debris on the insi On 02/03/22 at 3:15 conducted with Nurs from 7:00 AM to 7:00 that the staff did not routine basis and that he gave the resident During an observatic Resident #19 on 02/Resident pointed to that was half full of vishe still did not have On 02/05/22 at 10:40 conducted with Nurs she worked 7:00 PM explained that fresh every day and that in cup every day as we On 02/05/22 at 11:40 conducted with Nurs explained that fresh once a shift and the every day on third should be on 02/05/22 at 12:20 conducted with Nurs first and second shift fresh ice water was the ice cups were characteristics.	The Resident stated it had she has had a new ervation of the cup revealed de of the cup. PM an interview was e #2 who stated he worked D PM. The Nurse explained pass out fresh ice water on a at he gave extra fluids when is their medications. On and interview with 04/22 at 3:05 PM the her undated Styrofoam cup water. The Resident stated of fresh water. O AM an interview was as a Aide (NA) #15 who stated to 7:00 AM. The NA ice water was passed out included changing out the ice is a AM an interview was a Aide (NA) #7 who ice water was passed out ice cups were changed out	F	307		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` ′	X3) DATE SURVEY COMPLETED	
		345128	B. WING			l	C	
NAME OF D	ON (IDED OD OUDDUIED	343120	B: Wilte		TREET ADDRESS SITY STATE 7/D SODE	02/	23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812 SS=E	ice water should be p and the end of the sh Styrofoam cups shou third shift. An interview was con #17 on 02/10/22 at 12 that he worked first at passed out fresh ice with checked at 10:00 AM resident needed more ice chest stayed on the residents requested. On 02/07/22 at 3:45 Fithe Administrator and (DON) the Administrator and (DON) the Administrator council voiced a concice water on a routine in place that ice water shift and upon request would be given out or Administrator continuing monitored the system hit the building and the which caused the faciliand the system fell the stated she was not aw not getting fresh ice we expectation for the rewater every shift and Food Procurement, St	AM to 7:00 PM and fresh assed out at the beginning iff. The Nurse stated the Id be changed every day on ducted with Nurse Aide (NA) 2:10 PM. The NA explained and second shift and he water in the mornings and and after lunch to see if the exact. The NA stated the le hall for easy access when led more water. PM during an interview with Interim Director of Nursing tor confirmed that Resident tern about not getting fresh abasis and she put a system of would be passed out every stand that a fresh water cup in third shift. The led to explain that she for a while and then COVID le vaccine was mandated lity to be staff challenged rough. The Administrator ware that the residents were water but that it was her sidents to get fresh ice a new water cup every day. ore/Prepare/Serve-Sanitary 2)		807			3/25/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 2/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		ZIZJIZUZZ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	state or local authorit (i) This may include from local producers, and local laws or regulation (ii) This provision does facilities from using planders, subject to consider a safe growing and food (iii) This provision does from consuming food from consuming food from consuming food standards for food settle and food from consuming food standards for food settle and food from consuming food standards for food settle food from consuming food standards for food settle food food from consuming food standards for food settle food food from consuming food standards for food settle food food food food food food food foo	re food from sources red satisfactory by federal, ries. rood items obtained directly subject to applicable State ulations. res not prohibit or prevent roduce grown in facility compliance with applicable d-handling practices. res not preclude residents res not procured by the facility. I prepare, distribute and roce with professional rvice safety. The is not met as evidenced road staff interview the re expired milk from 2 of 2 reas (reach in refrigerator red to seal open food items in reach in freezer and red to remove 2 heads of respoilage from 1 of 2 reas (refrigerator). These rential to affect food served the reach in refrigerator was respondent to the residence of reach in refrigerator of reach in refriger	F8	How corrective action will be accomplished for those reside have been affected by the defipractice; The facility failed to remove exfrom refrigerator storage area. discarded on 2/2/22. The facility failed to seal open and failed to remove spoiled it discarded on 2/2/22. How the facility will identify oth having the potential to be affect same deficient practice; Effective 3/14/2022 Dietary starty storage, refrigerator and frection for expired and/or open.	cicient copired milk Item food items em. Items her residents cted by the aff checked eezer		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 2/23/2022	
NAME OF PE	ROVIDER OR SUPPLIER	0.10.120	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	212312022	
TO UNIC OF TH	TO VIDEN ON OUT FILEN			520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	/ILLE		STATESVILLE, NC 28677			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 812	Continued From page	e 194	F 8	12			
	expired items. Cook #	ator/freezers and removed f1 instructed one of the rd the expired milk and		unwrapped food items. No add concerns identified.	itional		
	stated that the Dietar to the facility.	y Manager was on her way		Address what measures will be place or systemic changes made ensure that the deficient practic	de to		
	on 02/02/22 at 6:47 A	the refrigerator was made M along with Cook #1. The		recur:			
	expired on 01/27/22, that expired on 01/30 milk that expired on 0 heads of cabbage that in the refrigerator and black/brown leaves of heads of cabbage. The dogs that were open. Cook #1 was intervied. Cook #1 stated that go went through refrigerate expired items. She st	n the outer layers of both nere was also a bag of hot		Effective 3/24/2022 Dietary Ma designee educated dietary staf discarding spoiled items, expire and when opening items, wrap date items. The Dietary Manag cooks will monitor dry storage, and freezer section for spoilage and/or open and unwrapped fo daily during their shift. Effective 3/24/2022 newly hired staff will be educated during or Dietary Manager discarding ex and when opening items wrappend dating.	f on ed items, , label and eer and refrigerator e, expired od items d dietary ientation by pired items,		
	instructed one of the expired milk and state	with the item. Cook #1 dietary aides to discard the ed that the Dietary Manager e facility and could decide abbage.		Indicate how the facility plans to its performance to make sure the solutions are sustained: An audit will be completed by E	hat		
	made on 02/02/22 at #1. The observation r that were open to air The cookies appeare them. There was also	the reach in freezer was 6:41 AM along with Cook evealed 2 boxes of cookies and had not been sealed. d to have ice crystals on o an open bag of cinnamon		Manager or designee as follow weekly x 4 weeks, weekly x 4 v bi-weekly x 4 weeks. Results of these audits will be a monthly Quality Assurance Medical Control of the second of the seco	veeks, reviewed at eting for		
	sealed. There was no	en to air and had not been ice crystals noted on the obvious freezer burn.		further problem resolution if ne- Administrator will review the re- weekly audits to ensure any iss identified are corrected.	sults of		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG	(X3	3) DATE SURVEY COMPLETED
		345128	B. WING _			C 02/23/2022
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		01/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	Cook #1 was intervie She stated that all op	e 195 wed on 02/02/22 at 6:49 AM. en items should be labelled I be sealed up when done	F 8	Completion date: 3/25/2022		
	02/03/22 at 9:27 AM. who put things in the supposed to date ever days out." The Cooks checking to ensure the expired. The DM expithe facility had not go truck, and they had to the next truck was de added that she had in to throw out the expiradamant that the staff open a bag, they mus "they got lazy." The Ecabbage should have leaves turned brown/					
F 835 SS=K	3:40 PM. The Admini- expected all expired fi discarded and any op- resealed and dated. Administration CFR(s): 483.70	en food item should be	F 8	35		3/25/22
	enables it to use its re efficiently to attain or practicable physical, well-being of each res	mental, and psychosocial				

		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			1	C / 23/2022	
NAME OF D	ROVIDER OR SUPPLIER	0.0.20		27	FREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	23/2022	
TVAIVIL OF T	TO VIDER OR OUT FEET							
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET			
				S	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 835	Continued From page	e 196	F8	335				
	by:	iow and staff Nurse			How corrective action will be			
	Based on record revi					.1 4 .		
		d Physician interviews, the			accomplished for those residents found	ט נט		
		de leadership and oversight			have been affected by the deficient			
	obtaining PT/INRs (P	rstems were in place for Prothrombin Time Test/			practice;			
		zed Ratio) as ordered by the			Administration failed to have effective			
		icating laboratory results of			systems in place for obtaining PT/INRs	s as		
		toring and regulating of			ordered by the Physician/Nurse			
		ood thinner) dosage. The			Practitioner and communicating results			
	facility also failed to h	nave the supplies needed for			the PT/INRs for monitoring and regulat	ing		
	staff to obtain the PT/	/INRs for 1 of 1 resident			of Coumadin dosage. This failure			
	reviewed for unneces	ssary medication (Resident			occurred due to administration not			
	#1).				effectively monitoring compliance of			
					PT/INR management which resulted in	í		
	The immediate jeopa	rdy began on 12/17/21 when			Resident #1 PT/INRs not being comple	eted		
	the facility failed to ha	ave a system in place to			as per physician order and the medica	l		
	ensure orders for dail	ly PT/INRs were followed			provider not being notified of PT/INR			
	and supplies to obtain	n PT/INRs were available for			levels outside the given parameters of			
	staff to use. The imm	ediate jeopardy was			2.0- 3.0 for Resident #1.			
	removed on 02/8/22 v	when the facility provided						
	and implemented a ci	redible allegation of			How the facility will identify other reside	ents		
	immediate jeopardy r	emoval. The facility			having the potential to be affected by the			
	remained out of comp	oliance at a lower scope and			same deficient practice;			
	severity of a E (harm	that is not immediate						
	jeopardy) to ensure n	nonitoring systems put into			Effective 2/7/22, the Interim Director of	:		
	place are effective.				Nursing and licensed charge nurse			
					reviewed current facility residents with			
	Findings included:				orders for PT/INR labs to ensure labs a			
	J				being obtained as ordered and reporte			
	This tag is cross refer	rred to F757.			the physician/nurse practitioner. One additional resident identified with PT/IN			
	Based on record revie	ew and staff Nurse			results outside given levels not being			
		d Physician (MD) interviews,			documented as reported to the medica	ıl		
	, ,				provider as ordered. The licensed nurs			
	-	llow physician's orders for			•	Æ		
		Prothrombin Time Test/			notified Nurse Practitioner on 2/7/22.	.1 4		
		zed Ratio (PT/INR), a test			PT/INR flow record initiated, anticoagu	ıant		
		nd diagnose a bleeding			care plan and MAR updated by the			
	disorder or excessive	clotting disorder, laboratory			licensed nurse to include monitoring fo	r		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING			1	C 23/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	23/2022	
	101.52.1.01.1.00.1.2.2.1				20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE	
F 835	Continued From page	e 197	F	835				
F 835	(lab) studies. The face medical provider of all outside the perimeter residents reviewed for (Resident #1) which residents reviewed for (Resident #1) which results of a very large. The Administrator was jeopardy on 02/06/21. The facility submitted jeopardy removal plant. F835: Identify those result of the noncompact of the noncompact of the provider of the PT/INRs regulating of Coumact occurred due to administration failed to administration of Coumact occurred due to administer of the PT/INRs regulating of Coumact occurred due to administer of the provider not being no outside the given para Resident #1. Effective 2/7/22, the I and licensed charge if facility residents with ensure labs are being reported to the physician provider of the provider of the physician provider of the provider of the physician provider of the physician provider of the physician provider of the physician provider of the prov	ility also failed to notify the bnormal laboratory results is of 2.0-3.0 for 1 of 2 or unnecessary medications resulted in Resident #1 or abdominal surgery and ge hematoma. Is notified of immediate at 10:25 AM. The following immediate or an adverse outcome as a soliance: It have effective systems in T/INRs as ordered by the stitioner and communicating	F	835	adverse side effects and reporting to physician/nurse practitioner all PT/INR results and adverse side effects for follow-up intervention. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will no recur: 2/7/22, the Director of Regulatory and Risk Management provided education the Administrator, Interim Director of Nursing, SDC (Staff Development Coordinator) and Licensed Charge Nurses on the facility lab process and oversight of PT/INR management which includes ensuring the process is monitored by Administration for compliance. Effective 3/24/2022 Director of Nursing and/or designee educated current licer nurses on the facility lab process. Effective 3/24/2022 any License Nurse that has not been educated will not be allowed to work until receive education person or via telephone by Director of Nursing and/or designee. Effective 3/24/2022 all License Nurses including Agency staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on facility lab process.	o ot to h nse s in-		
	additional resident ide outside given levels r					or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D MANAGE				C
		345128	B. WING _			02/	23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
A C C O D D I	HE HEALTH AT CTATEON	/II.E		5	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES\	VILLE		S	STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	÷ 198	F 8	335			
	2/7/22. PT/INR flow re	d Nurse Practitioner on ecord initiated, anticoagulant			its performance to make sure that solutions are sustained:		
	nurse to include moni effects and reporting	• •			Effective 3/24/22, the Director of Nursii will monitor residents on Coumadin	ng	
	side effects for follow-				therapy for administrative oversight to ensure compliance with obtaining,		
		entity will take to alter the			reporting and monitoring as ordered		
		lure to prevent a serious n occurring or recurring, and			during morning clinical meetings and		
	when the action will b	•			weekly risk meetings x 12 weeks.		
	when the action will b	e complete.			Results of these audits will be reviewed	d at	
		istrator, Interim Director of ector of Operations and the			monthly Quality Assurance Meeting for further problem resolution if needed.		
		/ and Risk Management			Director of Nursing will review the resu	lts	
		Quality Assurance and			of weekly audits to ensure any issues		
		ement (QAPI) meeting to			identified are corrected.		
	-	nalysis of the facilities failure					
	to have an effective s Resident #1 PT/INRs	ystem in place for obtaining as ordered by the			Completion date: 3/25/2022		
	physician/nurse pract results of the PT/INRs	itioner and communicating s for monitoring and					
	regulating of Coumad						
	corrective action plan	was formulated to include					
	_	ent policy review without					
		lab process update, required					
		d needed follow-up reviews					
		QAPI Committee. Root					
		t Administration did not					
	_	ht of PT/INR management					
		nnce monitoring of system					
		re to obtain PT/INRs as					
	ordered for residents						
	communicating result						
		ating of Coumadin dosage.					
		esult of the facility not fully					
		process to include review of					
	meeting.	esults) during daily clinical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345128	B. WING _				23/2022
	ROVIDER OR SUPPLIER	/ILLE	•	STREET ADDRESS, CITY, STATE, ZIP COD 520 VALLEY STREET STATESVILLE, NC 28677)E	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 835	completed as ordered parameters not being medical provider. The Director of Regulatory provided education to Director of Nursing, S Coordinator) and Lice facility lab process an management which in process is monitored compliance. Licensed provide oversight to the ensure the PT/INRs and Additional monitoring PT/INRs should occur by the Administrator, and Licensed Charge lab process for PT/IN Nursing should ensur with review of all resist morning clinical meeting ensure labs (PT/INRs ordered with notification utside of the PT/INR notification should be record for the residen Administration (Direct Licensed Charge Nur re-education to Licensemonitoring of the PT/Inon-compliance from education should be considered with notification should be considered with parameters.	the lab process by ad in PT/INRs not being I and results outside communicated to the prefore, on 2/7/22, the and Risk Management the Administrator, Interim DC (Staff Development consed Charge Nurses on the doversight of PT/INR coludes ensuring the by Administration for I Charge Nurses should the Licensed Nurses to the obtained as ordered. The lab process for in morning clinical meeting Director of Nursing, SDC Nurses utilizing the facility R management. Director of the lab process is followed dents on Coumadin in the ting. The review should the provider for results parameters. This documented in the medical the by the Licensed Nurse. To of Nursing, SDC, or	F8	335			
	Licensed Charge Nur during orientation.	ses receive education					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _				23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	VILLE	•	STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	DE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRI <i>A</i>		(X5) COMPLETION DATE
F 835	On 2/7/22, the Region Services provided ed DON (Director of Nurnew process for PT/II clinical meeting. This charge nurses bringing the morning clinical meeting as communicated to Regional Director of the PT/INR flow recommorning clinical meet obtained as ordered aphysician. Additionall validating with the ph INRs are not within the level to ensure approinterventions were for from serious side effer Administrators, DONs receive education dureffective 2/7/22, the Immonitor residents on administrative oversignity with obtaining, report ordered during morning weekly risk meetings. Effective 2/7/22, the Immonitor residents on administrative oversignity of the physician/Nurse of the Physician of Coumand the Completed weekly effective 2/7/22, the Immonitor of Coumand the Physician/Nurse of the Physician/Nurse of the Physician of Coumand the Completed weekly effective 2/7/22, the Immonitor the Physician/Nurse of the Physician/Nurse of the Physician/Nurse of the Physician/Nurse of the Physician of Coumand the Physician of	nal Director of Clinical ucation to the Administrator, sing) and charge nurses on NR flow records review in new process includes ag PT/INR flow records to neeting. This responsibility to the charge nurses by the Clinical Services on 2/7/22. To the charge nurses by the Clinical Services on 2/7/22. To the charge nurses by the Clinical Services on 2/7/22. To the charge nurses during ing to validate labs are and reported to the y, education included ysician/nurse practitioner if the residents' therapeutic priate additional glowed to protect the resident exts. Newly hired and charge nurses will ring orientation. Director of Nursing will Coumadin therapy for goth to ensure compliance ing and monitoring as an g clinical meetings and the control of the print of the pri	F8	335			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(
		345128	B. WING _			02/	23/2022
	ROVIDER OR SUPPLIER US HEALTH AT STATES	/ILLE		52	TREET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	and weekly risk meetiongoing compliance a provide additional edunecessary. Monitoring Effective 2/7/2022, the form of Nursing will be ultir implementation of this removal for this allegeralleged Date of IJ Read A credible allegation was conducted in the review included an in-Regional Director of Ceducation to the Adminursing) and charge in PT/INR flow records in the importance of follow the importance of follow the importance of follow the importance of follow the importance of the provider also provided education Coumadin therapy which included the fol PT/INR perimeters, we current Coumadin dos to be drawn, as well as	T/INR monitoring system ing minutes to determine and effectiveness and to ucation and/or resource as g will be completed weekly. Administrator and Director mately responsible to ensure immediate jeopardy and noncompliance. Moval: 2/8/22 Validation for quality of care facility on 02/18/22. Record eservice training by the Clinical Services provided inistrator, DON (Director of nurses on new process for eview in clinical meeting. An ed for all nurses to include owing physician's orders for id reporting all abnormal promptly. The in-service on on monitoring residents by utilizing PT/INR logs lowing for each resident: set	F	335			
F 867 SS=H	QAPI/QAA Improvem CFR(s): 483.75(g)(2)(F	367			3/25/22
	§483.75(g) Quality as §483.75(g)(2) The qu	sessment and assurance.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_		Ι,	c l	
		345128	B. WING _				23/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				52	20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	SVILLE		S	TATESVILLE, NC 28677			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 867	Continued From pag	ne 202	E 9	367				
	· -			301				
	assurance committe							
		lement appropriate plans of						
		ntified quality deficiencies;						
		T is not met as evidenced						
	by:							
		ons, record reviews and			How corrective action will be			
	-	's Quality Assessment and			accomplished for those residents found	i to		
		ommittee failed to maintain			have been affected by the deficient			
		ures and monitor the			practice;			
		e committee put into place on						
		or 10 deficiencies in the			The facility failed to maintain implemen			
		and Homelike Environment,			procedures and monitor the interventio	ns		
		essments and Timing,			that the committee put into place on			
		ments, Baseline Care Plans,			10/15/21 for F584, F636, F641, F655,	20		
	Activities of Daily Liv	- ·			F677, F684, F686, F689, F812 and F8	30.		
		to Prevent/Heal Pressure						
	Ulcers and Food Pro				How the facility will identify other reside			
		/Sanitary and Infection			having the potential to be affected by the	ie		
		ginally cited on the 09/03/21			same deficient practice;			
	-	/. The continued failure of the			Effective 3/24/2022 Overlity Assessment	. 4		
		o federal surveys showed a			Effective 3/24/2022 Quality Assessmer and Assurance committee will review	it		
		's inability to sustain an						
	-	essment and Assurance			previous Quality Assessment and			
	Program.				Assurance minutes and ongoing			
	The finalines in alreda	٠.			monitoring monthly to ensure repeat			
	The findings included	u.			citation does not occur.			
	This citation is cross	ed referred to:			Address what measures will be put into)		
					place or systemic changes made to			
	F-677 Based on obs	ervations, record review,			ensure that the deficient practice will no	ot		
		amily member interview the			recur:			
		de incontinence care when						
		ident (Resident #3, Resident			Effective 3/24/2022 Administrator will			
		sident #10, Resident #11) and			implement monthly QAPI meetings			
		wer activities (Resident #2,			instead of quarterly QAPI meetings to			
		esident #12) for 8 of 8			ensure the continue review and			
		r activities of daily living.			monitoring of the continued compliance	of		
		, ,			previously cited deficient practices.			
	During the recertification	ation survey completed on			Corrective action will be implemented a	iS		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			l	C
NAME OF D	ROVIDER OR SUPPLIER	040120			FREET ADDRESS, CITY, STATE, ZIP CODE	02	/23/2022
NAIVIE OF PI	ROVIDER OR SUPPLIER				, ,		
ACCORDI	US HEALTH AT STATES\	/ILLE			20 VALLEY STREET		
				S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE
F 867	Continued From page	÷ 203	F8	367			
		ailed to provide showers for dent reviewed for Activities			necessary and may include additional monitoring, education or process upda as determined by the QAPI committee.		
	F-684 Based on obseresident, and staff interfollow physician order stasis ulcer (Resident physician order for treulcer (Resident #18), physician order for tree (Resident #6) for 3 of During the recertificat 09/03/21 the facility far anticoagulation medic residents reviewed for and failed to provide a for 1 of 1 resident reversident, and staff interiovestigate a fall and resident's smoking as	eatment to a diabetic foot and failed to follow eatment of surgical wounds 5 residents reviewed. ion survey completed on ailed to hold an eation as ordered for 1 of 5 runnecessary medications a daily treatment as ordered iewed for skin condition. ervations, record review, erview this facility failed to failed to update a smoking seessment when the			Indicate how the facility plans to monitority performance to make sure that solutions are sustained: Administrator will audit Quality Assurar monthly x 3 months to ensure procedurare implemented and monitored to ensure deficient practices maintain compliance. Monitoring tools will be reviewed for accuracy. Completion and ongoing compliance. Results of these audits will be reviewed monthly Quality Assurance Meeting for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	or ace res ure e.	
	resident was safe to see (Resident#3) for 1 of accidents and failed to that was left lying on a where residents and see intermittently for 1 of During the recertificate 09/03/21 the facility far admission smoking as the resident was a safe to see (Resident#3).	3 residents reviewed for o secure a full oxygen tank a table in the facility chapel staff were noted to visit 1 chapel observed. ion survey completed on ailed to complete a new seessment to determine if fe smoker or needed oking cigarettes for 1 of 2					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C
	ROVIDER OR SUPPLIER US HEALTH AT STATES			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	I	02/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 867	the facility failed to re 2 refrigerator storage and refrigerator), faile 2 of 4 storage areas refrigerator) and faile cabbage with signs or efrigerator storage a practices had the pot to residents. During the recertifica 09/03/21 the facility failed and label a frozen for walk-in freezer. Thes to affect food served F-880 Based on obseinterviews with staff, the Medical Director implement their infect procedures and the Cand Prevention (CDC when 2 of 2 Nurse Air to wear eye protection encounters and did in hand hygiene before facility also failed to figuidelines for resider Droplet Control Precamembers (Housekee failed to don/doff requency in addition, wear her mask to covand did not doff glove hygiene. These observed.	ervations and staff interview move expired milk from 2 of areas (reach in refrigerator ed to seal open food items in (reach in freezer and do to remove 2 heads of f spoilage from 1 of 2 reas (refrigerator). These ential to affect food served tion survey completed on ailed to discard expired food od item stored in 1 of 1 e practices had the potential to residents. Ervations, record review and Nurse Practitioner (NP), and (MD), the facility failed to tion control policies and center for Disease Control (2) guidance for COVID-19 des (NA #1 and NA#2) failed in during resident care of doff gloves and perform entering the hallway. The collow CDC recommended autions (ECDP) when 2 staff per #2 and Nurse #10) and uired personal protective we gloves and perform hand Housekeeper #1 did not wer both her mouth and nose	F8	67		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		1 02/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	09/03/21 the facility infection control gui member was observance washcloth in the flooresident and failed thand hygiene betwee residents who residents facility failed confusion of the facility compared time frame (Resident #3, Resident #3, Resident #3, Resident for 1 of resident assessment for 1 of resident assessment for height of 3 residents revious puring the recertification of the facility confusion of the facility of the facility confusion of the facility confu	ration survey completed on failed to follow general delines when 1 of 1 staff wed throwing a feces soiled or after providing care to a to remove gloves and perform een providing care to 2 ed in the same room. For a review and staff interview eassessments with the ea assessments within the for 3 of 3 resident reviewed lent #6, and Resident #7). Fation survey completed on failed to complete a imum Data Set (MDS) of 4 resident reviewed for each of the facility failed to admission minimum data set ght and discharge planning for lewed (Resident #4).	F	967			
	Minimum Data Set reviewed for discha reviewed for unnece of 5 residents reviewed. F-655 Based on received the facility failed to the faci	failed to accurately code the (MDS) for 1 of 2 residents rge, for 1 of 5 residents essary medications, and for 1 wed for resident assessment. cord review and staff interview develop a baseline care within on that addressed surgical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER	ESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO	
F 867	1 of 3 residents review. #6). During the recertific 09/03/21 the facility care plan in the are of admission for a refor 1 of 2 residents. F-686 Based on obstaff, Resident, Wo interviews the facility necessary goods a integrity for a reside breakdown. Reside assistance after smobserved with a stapressure ulcer will ulcer deepens, musmaking infection a for) on his right but provide pressure ulcersidents (Residen reviewed for pressure During the recertification.	cation survey completed on a failed to develop a baseline as of smoking within 48 hours resident who elected to smoke reviewed for smoking. Servation, record reviews, und Physician and Physician ty failed to provide the nd services to maintain skin ent with a history of skin ent #2 called for staff nelling a foul odor and was age IV pressure ulcer (the become very deep and as the scle or bone may be visible, strong possibility if not cared tock. The facility also failed to deer treatments for 2 of 3 the facility and Resident #18)	F 80	,		
	F-584 Based on obstaff interviews the cabinetry in 1 of 2 ipaint and/or repair (Room #134, Room	ordered for 1 of 2 residents are ulcers. servations, record review, and facility failed to repair resident dining areas, failed to dry wall in resident rooms in #234, and Room #229), soiled brief in the floor (Room				
	#116), failed to rem	nove a large bag of soiled linen failed to clean a spill of feeding				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	
		345128	B. WING		02/2	3/2022
	ROVIDER OR SUPPLIER	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 867	4 hallways. The facilit bedside table that had 1 of 1 resident review During the recertificat 09/03/21 the facility fadry wall in resident rorooms on 2 of 4 resident rooms for 4 of 4 resident rooms for 4 of 4 resident hallways from the provide clean linen for for linen, and failed to belonging from being	floor (Room #102) for 2 of y also failed to repair a d a missing drawer facing for ed (Resident #2). ion survey completed on ailed to repair and/or paint toms for 12 of 53 resident ent hallways, failed to clean of 53 resident rooms on 2 of tom debris and litter, failed to r 1 of 4 resident personal lost or misplaced for 3 of 4	F 86	57		
Γ 000	the Administrator, Renurse (RQAN), Direct Unit Manager #1 and explained that after the facility underwent in several key manage DON, Admission Direct then losing a lot of stavaccine mandate made amount of time on authat put in place. The explain that it was different from the proposed for the new DON in place approval to hire more Nurse she thought it to the stability of the factorial explaints.	PM during an interview with gional Quality Assurance for of Nursing (DON) and #2 the Administrator is recertification follow up multiple unplanned changes ement positions such as the ctor and Social Worker and left because of the COVID de it difficult to spend the ditting the plan of corrections Administrator continued to ficult to focus on one thing llenge) and she depended lobs and in some cases that RQAN stated that now with a and with Corporate staff and a Certified Wound will make an improvement in lity.	For			0/05/00
F 880 SS=E	Infection Prevention & CFR(s): 483.80(a)(1)		F 88	30		3/25/22

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		345128	B. WING		C 02/23/2022	
	ROVIDER OR SUPPLIER US HEALTH AT STATE	SVILLE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/23/2322	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 880	Continued From page	ge 208	F 880			
	infection prevention designed to provide comfortable environ development and tradiseases and infection program. The facility must est and control program a minimum, the following for the providing services the arrangement based conducted accordinaccepted national states and communicable staff, volunteers, visproviding services the providing services the providing services the procedures for the put are not limited to (i) A system of surverpossible communication infections before the persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and traditional states are possible communicable disease reported; (iii) Standard and traditional states are possible communicable disease reported; (iii) Standard and traditional states are provided to provide the persons in the facility of the persons in	tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Item for preventing, identifying, sing, and controlling infections diseases for all residents, sitors, and other individuals upon the facility assessment g to §483.70(e) and following tandards; In standards, policies, and program, which must include, or eighlance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions				
	(iii) Standard and tra to be followed to pre	event spread of infections; solation should be used for a				

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F 880	depending upon the involved, and (B) A requirement to least restrictive post circumstances. (v) The circumstances disease or infected contact with reside contact will transmit (vi)The hand hygie by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual of the facility will contact literature and the corrective actions to the facility will contact literature and the facility will be facility will contact literature and the facility will be facility will be facility will contact literature and the facility will be facility w	curation of the isolation, a infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byces with a communicable skin lesions from direct into or their food, if direct the disease; and the procedures to be followed direct resident contact. Setem for recording incidents a facility's IPCP and the taken by the facility.	F 88	,	
	interviews with staft the Medical Director implement their information (CI when 2 of 2 Nurse to wear eye protect encounters and dichand hygiene before	tions, record review and f, Nurse Practitioner (NP), and or (MD), the facility failed to ection control policies and e Center for Disease Control DC) guidance for COVID-19 Aides (NA #1 and NA#2) failed cion during resident care I not doff gloves and perform re entering the hallway. The ofollow CDC recommended		How corrective action will be accomplished for those residents four have been affected by the deficient practice; Effective 2/25/21 Nurse Aide #1, Nurse Aide #2, Nurse #10, Housekeeper #1 Housekeeper #2 received corrective action and reeducation on appropriate infection prevention practices including	se and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C)2/23/2022	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE,		I LOI LOLL	
				520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677			
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F 880	Droplet Control Preca members (Housekee failed to don/doff requ equipment and remov hygiene. In addition, wear her mask to cov	at 's room labeled Enhanced autions (ECDP) when 2 staff per #2 and Nurse #10) and uired personal protective we gloves and perform hand Housekeeper #1 did not wer both her mouth and nose	F 8	appropriate use of PPE and preventing cross c during direct and indire Education validated by completion.	ontamination ect resident care. competency		
	, , ,	es and perform hand ervations occurred for 5 of 5 red for infection control		How the facility will identify having the potential to same deficient practice. All residents have the paffected by the alleged	be affected by the e;		
	Infection Control" imp part: all staff are to as potentially infected or that could be transmi resident care services adhere to "Standard spread of infection. It have contact with resenvironments wear p equipment as appropactivities and at other	Effective 3/14/22 current staff members on the standard Precautions of are to assume all residents are infected or colonized with an organism of the transmitted during providing of eservices. Therefore, all staff shall of the standard Precautions to prevent the infection. It further read, all staff who out with residents and/or their of as appropriate during resident care of at other times in which exposure to y fluids, or potentially infectious likely.		rounding evelopment signee wearing eye gloves and d hygiene after nt staff member rounding evelopment			
	Equipment policy dat included the use of go protection (face shield respiratory protection mouth. It further reve as part of universal p	d or goggles), and covering the nose and aled gloves were to be worn recautions, hand hygiene before and after application,		place or systemic chan ensure that the deficier recur: Effective 3/24/22 Direct and/or will educate curperforming proper hand appropriate PPE use in eye wear and proper halinens to prevent the specific changes and proper the specific contents.	tor of Nursing rent staff on d hygiene, andling wearing andling of soiled		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
			A. BOILDII	_			С
		345128	B. WING _			l	23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	
A C C O D D I	HE HEALTH AT STATES	E		52	20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE		S	TATESVILLE, NC 28677		
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F 880	(CDC) guidance titled Prevention and Contr Healthcare Personne Disease 2019 (COVII 09/10/21 indicated that the section "Implement Protective Equipment (HCP): If SARS-CoV-in a patient presenting symptom and exposurin facilities located in high transmission should be described below: Eye a face shield that cover the face) should be we encounters. The CDC Covid19 Tr. 02/02/22 and revealed the red (high) for transition on revealed Housekeeps entrance door to allow wearing a mask below bilateral hands. Hous using the keypad them the 3 visitors (surveyothen immediately turn proceeded back to the walking past resident hallway, Housekeeps remove her gloves bestered to the surveyor them immediately be seen thallway, Housekeeps remove her gloves bestered to the surveyor them immediately be seen thallway, Housekeeps remove her gloves bestered to the surveyor than thallway, Housekeeps remove her gloves bestered to the surveyor than thallway, Housekeeps remove her gloves bestered to the surveyor than thallway, Housekeeps remove her gloves bestered to the surveyor than t	se Control and Prevention I "Interim Infection of Recommendations for I during the Coronavirus D-19) Pandemic" updated on e following information under int Universal Use of Personal if for Healthcare Personnel 2 infection is not suspected g for care (based on ure history), the HCP working counties with substantial or ould also use PPE as e protection (i.e., goggles or ers the front and sides of from during all patient care acker was reviewed on d that Iredell County was in smission of COVID19. 02/02/22 at 5:30 AM er #1 approached the front w visitors to enter the facility w her chin and gloves to ekeeper #1 opened the door in pushed the door open for ors) to enter the building and left the visitors and the residential care unit. While the both in the front lobby and the residential care unit. While the short in the front lobby and the residential care unit to before opening the door nor the before continuing to clean the continuing to clean	F	380	Effective 3/24/22 any staff that has not been educated will not be allowed to w until receive education in- person or via telephone by Director of Nursing and/o designee. Effective 3/24/22 all staff including Age staff before their first assignment, will be educated in orientation in person by Director of Nursing and/or designee on "performing proper hand hygiene where providing incontinence care Indicate how the facility plans to monitoritis performance to make sure that solutions are sustained: Director of Nursing will audit three designated staff members weekly x 4 weeks, bi-weekly x 4 weeks, monthly x for proper hand hygiene, PPE use and linen handling. Results of the audit will reported to the Administrator. Any staff found not to be following infection conting protocols will have progressive disciplinary action. Results of these audits will be reviewed monthly Quality Assurance Meeting for further problem resolution if needed. Director of Nursing will review the resure of weekly audits to ensure any issues identified are corrected. Completion date: 3/25/2022	ork a r ncy be f rol	
		2/22 at 5:35 AM with					

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		345128	B. WING				23/2022
	ROVIDER OR SUPPLIER	VILLE		5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677		
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F 880	residential care areas services. She indicate should have removed hand hygiene before An interview on 02/03 Staff Development Co Control Nurse (IC) reto always follow the Orecommendation and before and after PPE The Housekeeping S for interview on 02/04 An interview on 02/04 Administrator and Intervealed they expecte recommendations to always covering her recommendations to always covering her recommendation on revealed Nurse Aide at the nurses' station station counter with g she went over to the speaking to the nurse #1 was observed to be she was not wearing gloves on both hands perform hand hygiene station and medication. An interview with NA revealed she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be she was unawear eye protection were provided to be prov	ed to clean community and perform laundry ed she was aware she liber gloves and performed opening the front entrance. 8/22 at 11:00 AM with the cordinator (SDC) /Infection wealed she expected all staff CDC guideline perform hand hygiene usage. 1/22 at 3:30 PM. 8/22 at 12:20 PM with the erim Director of Nursing ed all staff to follow the CDC wear a face mask correctly nose and mouth. 1/2/2/2/2/2 at 5:38 AM (NA) #1 was in the hallway touching the nurses 'loves on both hands. Then med cart and began at the medication cart. NA he wearing a face mask, but eye protection and had and was not observed to be before touching the nurses' in cart. #1 on 02/02/22 at 5:39 AM aware she was required to when in a residential care ed she should not have had	F	8880			

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F 880	surfaces from not reperforming hand hygon A follow-up interview NA #1 revealed that first night working in provided a facemask offered eye protection and she had been to required eye protection and she had been to required eye protection. An interview on 02/0 Administrator and Intervealed they expect recommendations to while in the facility, thallway, and perform touching environments. An observation on revealed she was in 216) performing incompart wearing her face mathands. She was not perform hand hygien #2 was observed to the resident and tose bed while she placed resident. After compilied #2 picked up the brief to the hallway with her soiled glove brief in the trash receited the closed the lid and the standard process.	ntially contaminated multiple moving her gloves and iene. on 02/02/22 at 7:15 AM with night shift on 2/1/22 was her the facility and she was from the facility but was not n upon entry to the facility ld the only rooms that on were residents in the 8/22 at 12:20 PM with the terim Director of Nursing and all staff to follow the CDC always wear eye protection off gloves when in the shand hygiene before atal surfaces in the facility. 02/02/22 at 5:40 with NA # 2 ar resident's room (Room ntinence care. NA #2 was sk and gloves on both her observed to wear eyewear or e during the observation. NA remove the soiled brief from it to the	F 8	80		

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F 880	Continued From pa	ge 214	F 880			
	revealed she place there were no trash room. NA #2 indica potentially contamin when she opened thands nor did she placing the brief in care. NA #2 acknow placed the brief in and then placed it in hallway, removed hygiene before retund the placed she was a placed she brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a placed to be brief in a she was a	02/22 at 6:00 AM with NA #2 d the brief in the floor because a bag liners available in the ted she didn't think about nating the trash receptacle he lid using her soiled gloved know any alternatives to the floor during incontinence wedged she should have a disposable trash can liner in the trash receptacle on the ter gloves and performed hand trning to the resident's room. The was unaware eye protection of when providing care in the ts.				
	Administrator and li revealed they experecommendations to while in the facility. Not have put the britimmediately, disposibility, disposibili	08/22 at 12:20 PM with the nterim Director of Nursing cted all staff to follow the CDC o always wear eye protection Both indicated the NA should ef on the floor, but bagged sed of it in the trash can in the oves, and perform hand servation on 02/02/22 M and ending at 7:36 AM o in Resident #3's room with indicated EDCP which required gloves, face mask, and eye is staff were to perform hand of was wearing a face mask,				
	but not observed to or gloves upon entr Resident #3's bed a	don eye protection, a gown, y. Nurse #10 approached and spoke to him. Nurse #10 call light and exited the room				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	VILLE		STREET ADDRESS, CITY, STATE, 520 VALLEY STREET STATESVILLE, NC 28677	ZIP CODE	OLI LOI LOLL	
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F 880	door and pushed it d not observed to perform table. An interview on 02/1/4/10 revealed she that discontinued for Resonot think it was need placed on Resident # mask, eye protection be worn and hand hype was removed. No been educated to follow the signage she expected all statemask, and eye protection follow the signage She expected all statemask, and eye protectindicated staff should they enter and exit at hand hygiene. An interview on 02/0. Administrator and Intervealed they expect signage posted to income and the facemask, eye protection of the signage posted to income and the facemask, eye protection of the signage posted to income and the facemask, eye protection of the signage posted to income and the facemask, eye protection.	r bedside table outside the own the hallway. She was orm hand hygiene before hallway with the bedside 0/22 at 1:50 PM with Nurse ought the ECDP had been ident #3 and therefore did ed to follow the signage #3's door which indicated a regione completed when the Nurse #10 indicated she had low all posted signage for and she should have ene after exiting the room the bedside table in the 3/22 at 11:00 AM with the coordinator (SDC) /Infection exealed she expected all staff posted on resident doors. If to wear a gown, gloves, ction in these rooms. She is change all PPE each time in isolation room and perform 8/22 at 12:20 PM with the derim Director of Nursing and staff to follow the clude wearing full PPE of a ction, gown, and gloves and the before and after PPE	F8	880			

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NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP C 520 VALLEY STREET STATESVILLE, NC 28677	•	ZIZSIZOZZ	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETION DATE	
F 880	revealed Houseke #3's room wearing face shield in her outside of the door required the use of and eye protection perform hand hygher housekeeping of the cart to obta #2 then donned the a pair of gloves are solution then enter began cleaning surplickly returned the as a bag of trash of brush and returned toilet. Housekeeping brush to the cart apicked up the more began mopping the against the wall in Resident #3's min in Resident #3's min in Resident #3's min in Resident #3's but he overbed table and exited the roopushed her cart of Housekeeper #2 morning full PPE Resident #3's room about the need to PPE each time she	AM and ending at 7:54 AM seper #2 approached Resident g a face mask and carrying a hand. The signage on the prindicated EDCP which of a gown, gloves, face mask, an as well as staff were to giene. She laid the face shield on a cart and opened the side door in a plastic gown. Housekeeper the plastic gown, face shield and and grabbed a rag and a bottle of the room. Housekeeper arranged in the bathroom and the rag and spray bottle as well to the cart, retrieved a toilet do the bathroom to clean the errest then brough the dirty toilet and sat it on the cart surface, or and returned to the room and the floor. She sat the mop of the room and picked up it cooler and emptied the cooler and returned to the room and the floor. She sat the mop of the room and picked up it cooler and emptied the cooler and returned to the room and the floor. She sat the mop of the room and picked up it cooler and emptied the cooler and returned to the room and the floor. She sat the mop of the room and picked up it cooler and emptied the cooler and returned to the room and the floor. She sat the mop of the room and picked up it cooler and emptied the cooler and returned to the room and the floor. She sat the mop of the room and picked up it cooler and emptied the cooler and returned to the room and the room and picked up it cooler and emptied the cooler and returned to the room and the room and removed her PPE and the room an	F	380			
	Staff Developmen	2/03/22 at 11:00 AM with the t Coordinator (SDC) /Infection revealed she was new to the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODI 520 VALLEY STREET STATESVILLE, NC 28677	I	02/23/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETION IE APPROPRIATE DATE		
F 880	position, and she exp signage posted on re all staff to wear a gow protection in these ro should change all PP exit an isolation room. The Housekeeping S for interview on 02/04 Administrator and Intervealed they expecte signage posted to inc facemask, eye protect	ects all staff to follow the sident doors. She expected vn, gloves, mask, and eye oms. She indicated staff E each time they enter and and perform hand hygiene.	F	380			