STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 08/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 8/24/18. Event ID# YS6I11.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		9/24/18

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

Electronically Signed | 09/12/2018

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F 623	Continued From page 1	F 623		

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

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

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the resident or resident representative with written notification of the reason for transfer/discharge to the hospital and failed to send a copy of the notice to the Ombudsman for 2 of 2 residents (residents #115 & #137) reviewed for transfer/discharge to the hospital. The findings included: 1) Resident #115 was admitted to the facility on 4/10/18 with diagnosis which included Diabetes, chronic obstructive pulmonary disease and pulmonary hypertension. A review of the Minimum Date Set (MDS) records	F 623	Accordius Health at Creekside Care had misunderstood the regulation to require only notification of residents if the resident was being discharged against her/his will. A thorough review of the regulation and discussion with the Stste Survey Agency provided the clarification that all residents who have a discharge or transfer will receive written notification of the details of the transfer in accordance with the guidance of F623 On 9/1 Resident #115 was sent the discharge/transfer notice for the hospitalizations that occurred 05/11, 06/11	

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F 623	Continued From page 3 revealed she was discharged to the hospital on 5/11/18, on 6/10/18 and on 7/1/18. The most recent MDS a 30 day report dated 8/14/18 revealed Resident #115 was cognitively intact and she required extensive assistance for activities of daily living. During an interview with Resident #115 on 8/22/18 at 2:28 PM she was able to state the reason for each of the discharges from the facility to the hospital. She stated she had not received written notifications from the facility for any of the times she went to the hospital. The Director of Nursing (DON) was interviewed on 8/24/18 at 12:01 PM. She stated when a resident went to the hospital a Nursing Home to Hospital Transfer form and a copy of the bed hold policy was sent with the resident. The DON said she was not aware the facility had to send written notification to the resident or their responsible party or to the Ombudsman. During an interview with the facility Social Worker, the DON and the Administrator on 8/24/18 at 12:05 PM they stated they were not aware of the requirement to send written notification to the resident or resident representative and a copy to the Ombudsman of a residents transfer or discharge. The Administrator stated they had not provided any written information to the resident, responsible party or the ombudsman. 2) Resident #137 was admitted to the facility on 1/26/18 with diagnoses which included atrial fibrillation, diabetes and major depressive disorder.	F 623	and 07/01 with the details about the reasons for transfers, the effective date of the transfer/discharge and the location transferred to. In addition the resident received a document that included the right to appeal dischare as well as contact information for the local ombudsman. All residents who have been or will be discharged of transferred can be affected by this practice. To assure no resident has been adversely affected, the facility has issued a Notice of Discharge/Transfer to all residents who have been discharged or transferred since the facility became aware of regulatory discrepancy, 08/24/18. Each resident has received the letter which includes the reason for transfer, the effective date of transferred, the location to where the resident was transferred and for those residents who have a Level II PASSARs the contact information for the agency providing advocacy for that resident. Each has received the informational sheet that includes appeal of rights, contact information for the local Ombudsman. This was completed on 09/24/18. The Social Worker and the Director of Nursing have partnered to establish a system that provides this notification with the two documents being sent: 1) with the resident at the time of discharge or transfer or 2) to the residents primary contact and 3) to the Ombudsman along with other notices gathered in a batch and sent weekly. All notification letters will be	

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F 623	Continued From page 4 A review of the quarterly MDS dated 4/28/18 revealed Resident # 137 was cognitively intact and required extensive assistance with all activities of daily living except she was independent with eating. A review of the medical record revealed Resident #137 was sent to the hospital on 5/2218 for increased confusion. She did not return to the facility. The Director of Nursing (DON) was interviewed on 8/24/18 at 12:01 PM. She stated when a resident went to the hospital a Nursing Home to Hospital Transfer form and a copy of the bed hold policy was sent with the resident. The DON said she was not aware the facility had to send written notification to the resident or their responsible party or to the Ombudsman. During an interview with the facility social worker, the DON and the Administrator on 8/24/18 at 12:05 PM they stated they were not aware of the requirement to send written notification to the resident or resident representative and a copy to the Ombudsman of a residents transfer or discharge. The Administrator stated they had not provided any written information to the resident, responsible party or the ombudsman.	F 623	entered into a notification log which will be reviewed by the Administrator on a weekly basis. The system will be reviewed by QAPI in a log kept for all notifications. On a weekly basis. The director of Social Work will review the notification log against the transfer log to ensure all notifications are made on a timely basis. QAPI Committee will review this comparative review process on a monthly basis for 3 months, and then quarterly for 3 quarters to monitor for sustained compliance. The Administrator is responsible for sustaining compliance with this corrective action which will be fully implemented by 09/24/18	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		9/14/18

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(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,

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F 640	Continued From page 6 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and transmit discharge Minimum Data Set (MDS) assessments for 3 of 4 residents reviewed for discharge. (Resident #1, Resident #2, Resident #3) Findings included: 1. Resident #1 was admitted to the facility on 2/15/18. Resident #1's active diagnoses included peripheral vascular disease, end stage renal disease, and diabetes mellitus. Review of a nurse's note dated 4/17/18 revealed Resident #1 was discharged on 4/17/18. Review of the MDS assessments by the facility on 8/21/18 at 2:30 PM revealed the discharge assessment for Resident #1 was completed on 8/15/18. During an interview on 8/22/18 at 10:47 AM MDS Coordinator #1 and MDS Coordinator #2 stated discharge assessments were to be completed within seven days of discharge and transmitted within 14 days of completion. MDS Nurse #1 and MDS Nurse #2 stated the discharge assessment for Resident #1 should have been completed and transmitted prior to 8/15/18 and it was not. During an interview on 08/22/18 11:03 AM the Director of Nursing stated it was her expectation MDS discharge assessments be completed according to the Resident Assessment Instrument	F 640	1. Discharge MDS assessments have been completed for Resident #1, Resident #2 and Resident #3. 2. A 100% audit of discharges to discharge MDS transmissions has been conducted with any negative variances corrected at the time of observation. 3. The policy and procedure for the completion and transmission of MDSs is written in compliance with regulations. MDS staff have been re-educated on submission requirements. No systemic changes are warranted at this time. 4. MDS staff will run a bi-weekly transmission report and compare to the Notification of Discharge Log. This audit will verify if all discharges have been captured by the MDS staff. Any negative variances will be corrected at the time of observation. Audits will continue for two (2) months or until sustained compliance is achieved. An audit report will be provided to QAA for review and monitoring compliance. 5. Date of Compliance: 09/14/18	

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F 640	Continued From page 7	F 640		

(RAI) manual. She further stated it was her expectation the discharge assessment for Resident #1 be completed and transmitted prior to 8/15/18 and it was not done.

2. Resident #2 was admitted to the facility on 3/16/18. Resident #2's active diagnoses included chronic kidney disease, hypertension, diabetes mellitus, and heart failure.

Review of a nurse's note dated 4/4/18 revealed Resident #2 was discharged on 4/4/18.

Review of the MDS assessments by the facility on 8/21/18 at 2:30 PM revealed no discharge assessment had been completed or transmitted by the facility for Resident #2.

During an interview on 8/22/18 at 10:47 AM MDS Coordinator #1 and MDS Coordinator #2 stated discharge assessments were to be completed within seven days of discharge and transmitted within 14 days of completion. MDS Nurse #1 and MDS Nurse #2 stated the discharge assessment for Resident #2 should have been completed and transmitted prior to 8/22/18 and it was not.

During an interview on 08/22/18 11:03 AM the Director of Nursing stated it was her expectation MDS discharge assessments be completed according to the Resident Assessment Instrument (RAI) manual. She further stated it was her expectation the discharge assessment for Resident #2 be completed and transmitted prior to 8/22/18 and it was not done.

3. Resident #3 was admitted to the facility on 3/14/18. Resident #3's active diagnose included chronic kidney disease, diabetes mellitus, and

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F 640	Continued From page 8 osteomyelitis of the vertebra. Review of a nurse's note dated 4/10/18 revealed Resident #3 was discharged on 4/10/18. Review of the MDS assessments by the facility on 8/21/18 at 2:30 PM revealed no discharge assessment had been completed or transmitted by the facility for Resident #3. During an interview on 8/22/18 at 10:47 AM MDS Coordinator #1 and MDS Coordinator #2 stated discharge assessments were to be completed within seven days of discharge and transmitted within 14 days of completion. MDS Nurse #1 and MDS Nurse #2 stated the discharge assessment for Resident #3 should have been completed and transmitted prior to 8/22/18 and it was not. During an interview on 08/22/18 11:03 AM the Director of Nursing stated it was her expectation MDS discharge assessments be completed according to the Resident Assessment Instrument (RAI) manual. She further stated it was her expectation the discharge assessment for Resident #3 be completed and transmitted prior to 8/22/18 and it was not done.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to accurately code the MDS (Minimum Data Set) to reflect the wandering	F 641	The MDS and Social Worker failed to communicate the appropriate coding of a wandering resident due to an avoidable	9/24/18

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F 641	Continued From page 9	F 641		

behaviors exhibited by 1 of 27 residents (Resident # 133) reviewed for MDS accuracy.

The findings included:

Resident #133 was admitted to the facility 3/23/17 with diagnoses that included Alzheimer's disease and unspecified psychosis.

Review of Resident #133's most recent MDS assessment dated 8/7/18, coded as a quarterly assessment, the assessment specified no behaviors were present during the look back period.

Review of a note written by MDS Coordinator #1 dated 8/8/18 stated in part, "Resident wanders and paces the corridors daily constantly to the point of exhaustion but staff are unable to get her to sit down and rest."

Resident #133 was observed 8/20/18 at 12:16 PM walking down the hallway repeatedly. She was taken off the unit by MDS Coordinator #1 who explained she will supervise Resident #133 to give staff an opportunity to complete other tasks.

During an interview with Activity Staff #1 she reported that Resident #133 wanders daily and frequently sets off the door alarms in the unit.

An interview was conducted on 8/23/18 at 2:50 PM with MDS Coordinator #1. She stated that Section E of the MDS is completed by the Social Worker.

During an interview conducted 8/23/18 at 3:05 PM with the Social Worker she reported that

error. Because the Social Worker staff considered this constant pacing to be a normal, deliberate behavior on the resident's part, rather than aimless wandering, the Social Worker did not code it as wandering on the MDS and the MDS nurse failed to complete the double check process which would have shown this coding inconsistency. The coding error has been corrected.

All residents are placed at risk when communication is incomplete. The interdisciplinary team has been in-serviced on the residents at risk clinical process which is an opportunity to discuss residents who are exhibiting certain behaviors, being medicated for certain reasons, experiencing changes in weight, skin integrity or health conditions. Each resident who "triggers" is discussed by the team and a check of nurses notes, MDS, care plans and implemented processes is reviewed to ensure consistency in all. To fully cover residents in the facility, the regional team has reviewed the process with the interdisciplinary team and reinforced the standards to be used in this important weekly meeting.

The Director of Nursing oversees the residents at risk process and is responsible for fully implementing and conducting the weekly meeting. The Administrator will review data from the weekly meeting to ensure it is complete. The Regional Director of Clinical Services will review the process with the team and attend a meeting monthly times 3 months

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F 641	Continued From page 10 wandering should have been coded on the resident's MDS dated 8/7/18. She indicated it was a coding error on the resident's MDS assessment and it would be corrected by MDS Coordinator #1. An interview was conducted with the Director of Nursing on 8/23/18 at 3:35 PM she stated she witnessed Resident #133 wandering daily and it was a coding error. She indicated it was her expectation that MDS assessments are coded accurately. During an interview with the Administrator on 8/23/18 at 3:42 PM she stated it was her expectation that the MDS assessment gives an accurate representation of the patient.	F 641	in fully developing the meeting. The results of these meetings will be reported to QAA on a monthly basis time s 3 months with the QAA team determining the need to continue the monitoring based on findings. The Director of Nursing is responsible for implementing and the Administrator is responsible for ensuring the process is sustained. The corrective active will be fully implemented by 09/24/18	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to supervise 1 of 1 residents (Resident #337) reviewed for inappropriate behaviors. The findings included: Resident #337 was admitted to the facility on	F 689	The facility is responsible for fully assessing resident behavior and planning for the care of the resident based on that assessment which also includes observation and record review. Once observed or suspected behaviors are exhibited by a resident that may negatively impact others, there must be a	9/24/18

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F 689	Continued From page 11 8/3/2018 with diagnoses that included unspecified dementia with behavioral disturbance, chronic obstructive pulmonary disease, and chronic kidney disease. An admission Minimum Data Set (MDS) dated 8/10/18 indicated Resident #337's cognition was moderately impaired. He required supervision with one person assist for walking, locomotion, bed mobility, and transfer. Resident #337 required limited assistance with personal hygiene and extensive assistance with dressing and toilet use. Review of a nurse's note dated 8/4/18 revealed that Resident #337 was witnessed touching a female resident inappropriately. He was placed on observation with 1:1 care and direct visualization. An interview was conducted with Nursing Assistant #1 on 8/22/18 at 3:50 PM who stated she witnessed Resident # 337 touch another resident inappropriately on 8/4/18. She indicated she was standing at the nurse's station when she saw Resident #337 touch the other resident. Nursing Assistant #1 stated it happened very quickly. She reported that both residents should be supervised very closely. Nursing Assistant #1 added that he was receiving 1:1 supervision afterwards. She stated she was unaware why he was no longer supervised at that level. Review of a nurse's note dated 8/5/18 read in part, "no further behaviors noted overnight, direct monitoring has been lifted although close supervision continues". Review of a nurse's note dated 8/6/18 indicated	F 689	plan in place to reduce or eliminate the potential negative impact of the behavior. Resident #337 has been fully assessed with careful attention to inappropriate behaviors that may be disruptive or conflictual with others. Non-pharmacological interventions as well as a thorough medication review are now complete with medication adjustments made and careful monitoring in place. All residents are at risk when staff fails to recognize aberrant behavior with the potential to affect others. All residents have been screened through the at-risk meeting process with those who have unusual or potentially aberrant behaviors being noted with care plan decisions developed to minimize the impact of such behavior. The resident-at-risk meeting will continue to be held on a weekly basis. Residents with behaviors will be discussed with causes and solutions sought to reduce or eliminate behaviors. Behaviors discussed will be selected for review by the Administrator and Social Worker weekly for 6 weeks to assure proper plans are fully implemented. The results of this weekly meeting will be shared at the monthly QAA meeting for a period of 3 months with the review at that time to determine whether compliance is sustained. The Administrator is responsible for implementing and sustaining this	

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F 689	Continued From page 12 Resident #337 attempted to push another resident out of his way and struck a second resident during lunch meal service in the day room. During an interview with Nurse #2 on 8/22/18 at 10:55 AM she indicated she was present when Resident #337 attempted to push another resident. She stated she explained to Resident #337 if he had an issue with another resident to notify staff. Review of a nurse's note dated 8/20/18 revealed that Resident #337 was observed fondling and rubbing on a female resident's breast. The note stated the nurse aide spoke with resident and informed him it was inappropriate. An interview was conducted with Nursing Assistant # 2 on 8/22/18 at 9:50 AM. She stated that she witnessed Resident #337 touch the female resident on 8/20/18. Nursing Assistant #2 stated she immediately separated the two residents. She reported that she informed Resident #337 this was inappropriate. Nursing Assistant #2 stated she reported this to Nurse #2. During an interview with Nurse #2 on 8/22/18 at 10:55 AM she stated she did not witness Resident #337 touch another resident on 8/20/18. She indicated she responded when notified by a nursing assistant. Nurse #2 stated she notified her nurse manager. She reported that both families should have been notified and a care plan meeting should have been scheduled. During an interview with Nurse Manager #1 on 8/22/18 at 11:23 AM who stated she was unaware physical contact occurred between Resident #337	F 689	corrective action which will be in fully place by 09/24/18	

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F 689	Continued From page 13	F 689		

and another resident. She indicated it was her understanding that contact had been prevented by staff. Upon reading the nurse's note dated 8/20/18 she stated that she would follow-up with staff regarding the incident. She stated she planned to follow up with both resident's responsible parties regarding the incident. Nurse Manger #1 stated it is her expectation that she would be given accurate information by staff.

An interview was conducted with the Director of Nursing (DON) on 8/23/18 at 11:55 AM. She stated there was a brief interdisciplinary team meeting on 8/22/18. The DON indicated Resident #337's responsible party was advised on the incident on 8/22/18. She stated the facility is providing 1:1 supervision to the resident, which began on the afternoon of 8/22/18. She further stated the family has been encouraged to consider other options in the event the facility can no longer meet Resident #337's needs. She indicated it was her expectation residents would be supervised to prevent physical contact.

An interview was conducted with the Administrator on 8/23/18 at 12:13 PM who stated that Resident #337 would be on 1:1 supervision until a long-term solution can be developed. She reported she plans to work with the Activities Department to change their schedule to provide activities on the unit during times such as shift change to provide additional supervision. The Administrator added Resident #337 was diagnosed with a urinary tract infection upon admission and was being assessed for a second urinary tract infection. She indicated the resident would not be discharged for behaviors secondary to a urinary tract infection. The Administrator added it is her expectation that inappropriate

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F 689	Continued From page 14 physical contact between residents did not occur. During observations on 8/23/18 at 2:28 PM, 8/23/18 at 3:29 PM and 8/24/18 at 10:14 AM Resident # 337 was receiving 1:1 supervision by a nursing assistant.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		9/14/18

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F 756	Continued From page 15 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, pharmacist, and physician interviews, the facility failed to ensure the physician reviewed pharmacy recommendations and document any action taken or a rational for no action taken on the pharmacy request for 1 of 5 residents reviewed for unnecessary medications. (Resident #113) Findings included: Resident #113 was admitted to the facility on 12/11/17. Review of Resident #113's chart revealed the resident's diagnoses were history of falling, vascular dementia without behavioral disturbances, hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, glaucoma, muscle weakness, and personal history of transient ischemic attack and cerebral infarction without residual deficits. Review of Resident #113's orders revealed on 3/16/18 he was ordered Haloperidol give 2 milligrams by mouth at bedtime for sleep. On 6/4/18 the order was reduced to 1 milligram by mouth at bedtime for sleep and 0.25 milligrams by mouth as needed for agitation in the morning. No new diagnoses were documented.	F 756	1. The clinical record for Resident #113 was reviewed and the correct diagnosis entered for each medication. 2. A 100% audit of pharmacy recommendations for the past 60 days was completed to ensure a follow-up was completed. Any negative variances were corrected at the time of observation. 3. Subsequent to the monthly pharmacy review, Unit Managers will review all pharmacy recommendations for their respective units to ensure recommendations are implemented or the physician has documented a response in the residents' clinical record as to why the recommendation is not being acted upon. The Director of Nursing will meet with Physician #1 to review the importance of responding to pharmacy recommendations to promote best practices and maintain regulatory compliance. 4. The Director of Nursing or designee will conduct a 100% pharmacy recommendation audit times three (3)	

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F 756	Continued From page 16 Review of a pharmacy consultation report dated 8/22/18 revealed Pharmacist #1's request read in part: "REPEATED RECOMMENDATION from 6/14/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 5/16/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 4/16/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 3/22/2018: Please respond promptly to assure facility compliance with Federal regulations." The request continued and read in part: "...(Resident #113) receives an antipsychotic, haloperidol. Federal nursing facility regulations require that antipsychotic agents be used only with one or more of the following conditions: 1) Conditions other than dementia: - schizophrenia, schizo-affective or schizophreniform disorder - delusional disorder - hiccups -Tourette's Disorder - Huntington disease - psychosis in the absence of dementia - nausea/vomiting with cancer or its therapy - drug related psychosis/mania (e.g., steroids) -mood disorders (e.g. bipolar disorder, severe refractory depression and/or with psychotic features) -medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) 2) Behavioral or psychological symptoms of dementia (BPSD) 3) Symptoms or behaviors MUST present a DANGER to the resident or others AND one or both of the following: a) symptoms are due to	F 756	months to ensure sustained compliance. For the months of September, October and November the Director of Nursing will submit a written report documenting audit outcomes to the QAA Committee for their review. 5. Date of Compliance: 09/14/18	

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mania or psychosis (auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); OR b) care-planned interventions have been attempted, except in an emergency."

During an interview on 8/22/18 at 1:38 PM Pharmacist #1 stated she had to reissue a request for the exact diagnoses for Haloperidol several times for Resident #113. She further stated she had not heard back from Physician #1 who was Resident #113's physician. She stated she had requested the proper diagnoses on 3/22/18, 4/16/18, 5/16/18, and 6/14/18. She further stated she had not yet received a proper diagnosis for the use of Haloperidol for Resident #113. She stated she did not request it in July because she had requested it four times already and not received a diagnosis. The Pharmacist stated the physician had documented in June for Haloperidol to be used for agitation and as a sleep aide which was not appropriate. She further stated it was her expectation to hear back from the physician within sixty days for her requests and she had not. She further stated she regularly did not hear from Physician #1 when she made recommendations and she stated she did not believe the resident was being seen by psychiatric services.

During an interview on 8/22/18 at 4:20 PM Physician #1 stated she was Resident #113's physician. She further stated the resident was on Haloperidol for agitation and as a sleep aide. She further stated she was not sure if she was aware the pharmacist had recommended providing an acceptable diagnosis for Resident #113 as the use of Haloperidol for agitation and sleep aide was not appropriate. She stated she could not remember if she had reviewed any pharmacist

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F 756	Continued From page 18 recommendations for Resident #113 it should be in the chart. During an interview on 8/22/18 at 4:28 PM the Director of Nursing stated the facility had monthly pharmacy reviews for all residents' medications and concerns were identified in that manner. She stated it was her expectation there was communication between the pharmacist and physician. The documentation for this review would go into the resident's chart. She further stated she did not know why the recommendations had not made it to the physician, however she did know there were no pharmacist recommendations in Resident #113's medical records that had a response provided by the physician. The pharmacist would make a recommendation and send it to the facility. She stated then the facility would provide this recommendation to the physician during their rounds. She stated the physician then documented if he or she agreed with the recommendation and then that documentation went in the resident's chart and there was no documentation of a physician's response to the pharmacist's recommendation for a diagnosis of haloperidol. She concluded she did not know who would have been the individual on 3/22/18, 4/16/18, 5/16/18, and 6/14/18 responsible for placing the recommendation in the physician's box and stated perhaps they did go to the physician who did not document on them.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		9/14/18

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processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 20 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, pharmacist, and physician interviews, the facility failed to ensure an antipsychotic medication was used to treat a specifically documented diagnosis for 1 of 5 residents reviewed for unnecessary medications. (Resident #113) Findings included: Resident #113 was admitted to the facility on 12/11/17. Review of Resident #113's chart revealed the resident's diagnoses were history of falling, vascular dementia without behavioral disturbances, hypertension, benign prostatic hyperplasia without lower urinary tract symptoms, glaucoma, muscle weakness, and personal history of transient ischemic attack and cerebral infarction without residual deficits. Review of a nurse's note dated 3/15/18 at 9:09 PM revealed Physician #1 had ordered a change in medication for Resident #113. Physician #1 discontinued Ambien and ordered Haldol at bedtime. Review of a nurse's note dated 3/15/18 at 10:15 PM revealed Resident #113 received Haldol 2 milligrams given by mouth as a sleep aide. Review of Resident #113's orders revealed on	F 758	1. The correct diagnosis was entered in the clinical record for Resident #113. 2. A 100% audit was completed on all residents receiving psychotropic medications to ensure each had a diagnosis meeting the requirements that justify the use of psychotropic medications. 3. The policy and procedure for the use of psychotropic medications was reviewed and no systemic are warranted at this time. All nurse managers and charge nurses have been re-educated on the policy and procedure for the appropriate use of psychotropic medications and approved corresponding diagnosis. Unit Managers will review the medication regimen for each new admission on their respective units to ensure no psychotropic medications are prescribed without the appropriate corresponding diagnosis and documentation in the residents' clinical record. 4. The Director of Nursing and/or designee will conduct a 100% psychotropic drug audit on all new residents during the weekly risk meeting. Audits will continue times two (2) months	

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F 758	Continued From page 21 3/15/18 he was ordered Haloperidol 2 milligrams by mouth at bedtime for sleep. On 6/4/18 the order was reduced to 1 milligram by mouth at bedtime for sleep and 0.25 milligrams by mouth as needed for agitation in the morning. No new diagnoses were documented. Review of a pharmacy consultation report dated 8/22/18 revealed Pharmacist #1's request read in part: "REPEATED RECOMMENDATION from 6/14/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 5/16/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 4/16/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 3/22/2018: Please respond promptly to assure facility compliance with Federal regulations." The request continued and read in part: " ...(Resident #113) receives an antipsychotic, haloperidol. Federal nursing facility regulations require that antipsychotic agents be used only with one or more of the following conditions: 1) Conditions other than dementia: - schizophrenia, schizo-affective or schizophreniform disorder - delusional disorder - hiccups - Tourette's Disorder - Huntington disease - psychosis in the absence of dementia - nausea/vomiting with cancer or its therapy - drug related psychosis/mania (e.g., steroids) -mood disorders (e.g. bipolar disorder, severe refractory depression and/or with psychotic features) -medical illnesses with psychotic symptoms (e.g.,	F 758	or until sustained compliance is achieved. The Director of Nursing will submit to the QAA Committee the final monthly risk meeting document for review to validate the effectiveness of the weekly review process. 5. Date of Compliance: 09/14/18	

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neoplastic disease or delirium)
2) Behavioral or psychological symptoms of dementia (BPSD)
3) Symptoms or behaviors MUST present a DANGER to the resident or others AND one or both of the following: a) symptoms are due to mania or psychosis (auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); OR b) care-planned interventions have been attempted, except in an emergency."

During observation on 8/22/18 at 10:25 AM Resident #113 was observed out of bed and in his chair with his eyes closed. The resident was easily arousable and would respond to questions. He was able to answer some questions appropriately.

During an interview on 8/22/18 at 1:38 PM Pharmacist #1 stated she had to reissue a request for the exact diagnoses for Haloperidol several times for Resident #113. She further stated she had not heard back from Physician #1 who was Resident #113's physician. She stated she had requested the proper diagnoses on 3/22/18, 4/16/18, 5/16/18, and 6/14/18. She further stated she had not yet received a proper diagnosis for the use of Haloperidol for Resident #113. She stated she did not request it in July because she had requested it four times already and not received a diagnosis. The Pharmacist stated the physician had documented in June for Haloperidol to be used for agitation and as a sleep aide which was not appropriate. She further stated it was her expectation to hear back from the physician within sixty days for her requests and she had not. She further stated she regularly did not hear from Physician #1 when she made recommendations and she stated she did not

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believe the resident was being seen by psychiatric services.

During an interview on 8/22/18 at 4:20 PM Physician #1 stated she was Resident #113's physician. She further stated the resident was on Haloperidol for agitation and as a sleep aide. She further stated she was not sure if she was aware the pharmacist had recommended an acceptable diagnosis for Resident #113 as the use of Haloperidol for agitation and sleep aide was not appropriate. She further stated she was not aware that using Haloperidol for agitation and sleep were not appropriate causes to prescribe an antipsychotic medication. She further stated she would need to update the diagnosis list and then revisit the appropriateness of haloperidol during her next visit to the facility.

During an interview on 8/22/18 at 4:28 PM the Director of Nursing stated it was her expectation that there would be a clinical reason for antipsychotic use. She further stated the facility had monthly pharmacy reviews for all residents' medications and concerns were identified in that manner and it was her expectation there was communication between the pharmacist and physician. The documentation for this review would go into the resident's chart. She further stated she did not know why the recommendations had not made it to the physician, however she did know that no pharmacist recommendations were in Resident #113's medical records. The pharmacist would make a recommendation and send it to the facility. She stated then the facility would provide this recommendation to the physician during their rounds. She stated the physician then documents if he or she agreed with the recommendation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 08/24/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 24 then that documentation went in the resident's chart. She further stated she was unable to find any documentation of the physician providing an acceptable diagnosis for the use of haloperidol and no documentation of her response to the pharmacist recommendation for a diagnosis of haloperidol. She stated the resident was being seen by Neurology but not Psychiatric services.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		9/14/18

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F 761	Continued From page 25 Based on observations and staff interviews, the facility failed to dispose of expired medications in 1 of 3 medication storage rooms and 1 of 7 medication carts. Findings included: An observation was conducted on 8/21/18 at 10:00 AM of the West Annex Medication Storage Room. 1-100 tab bottle of Certirizine (a seasonal allergy medication) 100 milligrams (mg) was in the overstock cabinet and displayed an expiration date of 3/2018, and 1-3 pack box of Toujeo (an injectable insulin) 300 unit/mL (milliliter) with 1 unopened pen remaining was observed in the storage room refrigerator with an expiration date of 3/2018. An observation was conducted on 8/21/18 at 4:00 PM of the East Annex Medication Cart. The medication cart contained 1 bottle of Aspirin 325mg which expired 9/2017, 1 bottle of Omeprazole (a medication used for gastric reflux) 20mg which displayed an expiration date of 7/2018, and 1 bottle of Folic Acid 400 mcg (micrograms) with no discernable expiration date. An interview was conducted with Nurse #1 on 8/21/18 at 4:05 PM. She stated medications on the medication cart should have readable and legible expiration dates. If there was a medication without a discernible expiration date the bottle or package was to be discarded because the expiration date would be unknown. She also stated medication cart nurses were responsible for checking for expiration dates, and the carts and medication storage rooms were to be checked at the beginning of every shift. She also stated expired medications were to be removed	F 761	1. All expired medications were removed from the medication rooms and medication carts. 2. A 100% audit was conducted of all medication storage areas. Any expired medications are discarded in accordance with regulations governing the disposal or return of expired medications. 3. The process for the storage of over-the-counter (OTC) medications was changed to having one centralized location for the storage of OTC medications. The Central Supply Clerk is accountable for the ordering and storage of OTC medications. Charge Nurses have been educated on their responsibility to: 1) check the medication carts for expired medications 2) check the dates on all medications prior to placing them in the medication carts 3) check the medication refrigerators for expired medications and 4) check the crash carts for expired medications. Unit Managers will conduct random audits of medication storage areas on their respective units a minimum of one (1) time weekly; correcting and documenting any quality deficiency at the time of observation. 4. The Director of Nursing will conduct random bi-weekly inspections of the medication storage areas times twelve (12) weeks and provide a monthly report to the QAA Committee summarizing the	

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F 761	Continued From page 26 from the stock room or medication cart and discarded. An interview was conducted with the Director of Nursing on 8/21/18 at 3:15 PM. She stated over the counter medications stored in the medication storage room or medication carts and refrigerated medications in the medication storage room were not to be expired. She also stated over the counter stock medications were re-stocked from central supply after staff turned in expired medications to the central supply clerk. Expired prescription medications were returned to the supplying pharmacy. She also stated the hall supervisor or hall nurse was responsible for checking the medication carts to insure there were no expired medications. She stated her expectation was the medication storage rooms, refrigerators and medication carts contained no medications beyond the expiration date. She also stated all expiration dates were to be legible.	F 761	outcomes of the Unit Manager and Director of Nursing audits. 5. Date of Compliance: 09/14/18	