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 08/22/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 8/19/2019 through 8/22/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8ZBE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 8/19/2019 through 8/22/2019. Event ID # 8ZBE11. 8 of the 8 complaint allegations were not substantiated.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		9/9/19

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

Electronically Signed | 09/03/2019

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F 655	Continued From page 1 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to complete a baseline Care Plan within 48 hours of admission to address the immediate needs for 1 of 1 resident reviewed for a tracheostomy and sepsis from a urinary tract infection (Resident #232). The facility also failed to provide a copy of the baseline care plan summary for 1 of 2 residents reviewed for the completion of a baseline care plan (#114). The findings included: 1. Resident #232 was admitted to the facility on 8/1/19 and had a diagnosis of sepsis related to a urinary tract infection, acute and chronic respiratory failure and tracheostomy status. Review of the resident's care plan revealed the	F 655	1. Resident #232 has been discharged from the facility Resident #114 was provided a copy of the resident care plan. 2. Other residents had the potential to be affected by not receiving the baseline care plan in a timely fashion. A 100% audit will be conducted and completed by 09.06.19 by the nursing management team and MDS to identify any other residents and/or resident representatives (RR)/POA who have not received a copy of the Baseline Care Plan and/or the Comprehensive Care Plan. Any negative variance will be corrected at the time it is identified.	

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F 655	Continued From page 2 first entry was dated 8/4/19 that revealed the resident had behavioral problems. The care plan did not include information that the resident had a tracheostomy or had a history of sepsis related to a urinary tract infection prior to admission to the facility. There was no information related to the residents need for assistance with activities of daily living or if the resident was continent or incontinent of bowel or bladder. A 5 Day Minimum Data Set (MDS) Assessment dated 8/8/19 revealed the resident was cognitively intact and required extensive to total assistance with bed mobility, dressing, toileting, personal hygiene and bathing. The MDS noted the resident was frequently incontinent of bowel and bladder. The MDS revealed the resident received tracheostomy care. On 8/19/19 at 3:19 PM Resident #232 was observed lying in bed and was noted to have a tracheostomy (trach) and a nurse was observed in the room suctioning the resident's trach. On 8/21/19 at 8:47 AM an interview was conducted with MDS Nurse #1 and the facility's MDS Consultant. MDS Nurse #1 stated she understood the baseline care plan and the care plan was due in 14 days. The MDS Nurse further stated the comprehensive care plan had not been completed because the resident went back out to the hospital prior to the 14 days (8/10/19) and had just returned to the facility on 8/19/19. The MDS Consultant was observed to review the resident's clinical record and stated the resident did not have a baseline care plan and stated the baseline care plan should have been completed within 48 hours of the resident's admission to the facility on 8/1/19.	F 655	3. The facility has changed it□s system process regarding Baseline Care Plans to: i) Baseline Care Plans (BCP) are now opened in the patients□ electronic record by the admitting nurse or the unit manager ii) The day following admission the process is validated and other team members add pertinent information to the BCP iii) A copy of the BCP is provided to the resident and/or RR at the 72* meeting. Education regarding the Baseline Care Plan Process was provided to the Administrator, D.O.N., Social Workers and M.D.S. Coordinators by the Regional Nurse Consultant and the Regional Reimbursement Specialist on 08.21.19. Additional staff training in the completion of the BCP will include: the IDT, Nurse Managers and front-line licensed nursing personnel; education will be provided by the SDC and will be completed by 09.09.2019 MDS Coordinators will conduct daily audits on new admissions for twelve (12)weeks to ensure BCPs are opened in a timely manner and contain pertinent care information to ensure resident needs are addressed. 4. Audit outcomes will be reviewed by the QAA Committee times three (3) months or until sustained compliance is achieved.	

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F 655	Continued From page 3	F 655		

On 8/21/19 at 3:40 PM an interview was conducted with the administrator and the Director of Nursing. The Administrator stated it was her expectation that the baseline care plan be completed within 48 hours and include information needed to care for the resident.

2. Resident #114 was admitted to the facility on 7/16/19 and had a diagnosis of acute osteomyelitis of the left ankle and foot, chronic peripheral venous insufficiency and pain.

The Admission Minimum Data Set (MDS) Assessment dated 7/23/19 revealed the resident was cognitively intact.

On 8/19/19 at 11:12 AM an interview was conducted with Resident #114. The Resident stated soon after admission they talked with him about his care but he did not recall getting a copy of anything.

On 8/21/19 at 9:24 AM an interview was conducted with Social Worker #1. The Social Worker stated they held an initial care plan conference with the resident on 7/16/19 but the family was not present. The Social Worker further stated at the time of the baseline care plan meeting they do not print off anything to give to the resident but if the family was present they would print off the interdisciplinary care conference sheet and have the family sign it and give them a copy. The Social Worker was asked why she would not print a copy of the care conference sheet to give to an alert and oriented resident if the family was not present. The Social Worker stated if the family was not present they

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F 655	Continued From page 4 wait until the comprehensive care plan was complete and the RN (Registered Nurse) signed off on the care plan and gave it back to her and then she would give it to the resident. The Social Worker stated she received the resident's care plan on Friday and had planned to give Resident #114 a copy of the care plan on Monday (8/19/19) but did not and would give it to the resident today. On 8/21/19 at 3:38 PM an interview was conducted with the Administrator and the Director of Nursing. The Administrator stated it was her expectation the care plan process would be initiated on admission and a copy provided to the resident and/or family during the baseline care plan meeting.	F 655		
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	F 761		9/9/19

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F 761	Continued From page 5 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to lock an unattended medication cart for 1 of 6 carts observed (Medication Cart East Annex). The findings included: On 8/21/2019 at 8:40 AM, an unattended medication cart was observed angled in the hallway by Room 116, with the push-in lock observed to be in the out position. The nurse was not in view of the cart or visible from the open resident room #116. The nurse was observed to return to the cart after 2 minutes from a resident room several doors down the hallway. 2 staff members were in the hallway approximately 20 feet from the medication cart, in a discussion at the time. There were no residents observed in the hallway near the cart at the time. On 8/21/2019 at 8:42AM, an interview was conducted with the medication aid (MA), who stated a resident had hollered for her and she did not have time to lock the cart. The MA stated she usually took the unlocked cart from room to room with her, but she did not have time to take the cart with her and it was unlocked. On 8/21/2019 at 12:14 PM, an interview was conducted with the Director of Nursing (DON)	F 761	1. The Medication Aide who left the medication cart unlocked was educated and counseled by the SDC regarding the facility policy on the locking of medication carts. 2. Any resident within reach of an unlocked medication cart, that is not being visually monitored by staff could have been affected. To protect other residents from the potential negative outcomes from an unlocked medication cart, the SDC will provide all licensed nurses and Certified Medication Aides education on medication pass policy and procedures, including the locking of medication carts when the cart is not visually monitored. All education will be completed by 09.09.2019. 3. Facility policy and procedure has been reviewed and no revision or systemic change is warranted at this time. To further improve quality outcomes staff education and monitoring has been extended to include non-clinical staff. SDC will provide education to non-clinical staff about the importance of medication carts to always remain locked. Education will be completed by 09.09.2019.	

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F 761	Continued From page 6 who stated she expected staff to lock the medication carts when they were not in direct eye contact with the cart.	F 761	Compliance rounds will be completed by both clinical and non-clinical staff. Nursing Management and Administration will conduct random medication cart lock-security audits during routine med-pass observations. A minimum of seven (7) audits will be conducted and documented weekly, observing different nurses on different shifts. Any negative variance will be corrected at the time of observation with education and disciplinary action if warranted. 4. Audits will continue for three (3) months and outcomes provided to the QAA committee to monitor for sustained compliance.	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris for 1 of 1 dumpsters observed. The findings included: Review of the undated Food-Related Garbage and Rubbish Disposal, Policy Statement, reads as follows: 7. "Outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter." During an observation of the dumpster on 8/19/19 at 10:12 AM four disposable gloves, one plastic	F 814	1. The area around the trash compactor was cleaned of debris and equipment was power-washed. 2. Failing to properly dispose of garbage and refuse has the potential to have a negative impact on environmental sanitation. 3. All staff has been educated on the importance of properly disposing of refuse and garbage, including the need to check & correct the grounds for any garbage that may have fallen out of bags or boxes	9/9/19

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F 814	Continued From page 7 cup, straw papers and paper napkins were observed on the ground beside the dumpster. On 8/21/19 at 11:02 AM four disposable gloves, one plastic cup, straw papers and paper napkins were observed on the ground beside the dumpster. During an observation of the dumpster on 8/22/19 at 8:23 AM 5 disposable gloves, one plastic cup, straw papers and paper napkins were observed on the ground beside the dumpster. In an interview on 8/22/19 at 9:47 AM the Certified Dietary Manager stated she expected dietary staff to clean up the area surrounding the dumpster when they take out the trash. In an interview on 8/22/19 at 12:32 PM the Administrator stated she would expect all staff to clean up around the dumpster area when taking out trash.	F 814	being placed in the compactor at the time trash is carried outside to the compactor. Education was provided on various shifts and at diverse times by the administrator, dietary manager, housekeeping manager, DOR and other members of administration. All education will be completed by 09.09.19. To ensure garbage and refuse are disposed of properly in the compactor the Dietary Manager (and/or designee) will complete three (3) compactor ground checks per day (early a.m., early p.m. and end of day) times three (3) months; any negative variance will be corrected at the time of observation. Nursing, Environmental Services and Administration will conduct random audits five(5)times weekly for three (3) months with any negative variance corrected at the time of observation. 4. Audit outcomes will be submitted to members of the QAA Committee to ensure sustained compliance is achieved.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		9/9/19

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F 880	Continued From page 8	F 880		

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 9 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to disinfect a glucometer per the manufacturer's recommendations after use for 1 of 1 residents (resident #117) observed for glucometer cleaning. The findings included: The facility's policy titled Obtaining a Fingerstick Glucose Level, revised 10/2011 read: "3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. 18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice." Glucometer manufacturer's recommendations for cleaning and disinfecting were reviewed, and the facility used the recommended germicidal/disinfectant wipes. The instructions	F 880	1. The nurse who improperly cleansed the glucometer prior to checking the blood sugar on Resident #117, was educated by the SDC regarding proper policy and procedure for ensuring the equipment is sanitized. Resident #117 had no negative outcomes. 2. Failure to follow proper sanitation procedures for glucometers has the potential to result in negative outcomes. Two (2) other residents on this hall require FSBS glucose monitoring. The SDC interviewed Nurse #1 to identify the other residents who had their glucose checked prior to the glucometer being sanitized for the entire recommended 3-minutes. These two (2) residents were assessed and exhibited no signs or symptoms of any negative outcomes.	

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F 880	Continued From page 10 read: "4. . . .Allow the surface of the meter to remain wet for at least 2 minutes for (the wipe brand name) at room temperature. The manufacturer germicidal/disinfectant wipe instructions were visible on the wipe container and read: "5. . . . a 3-minute contact time is required to kill Clostridium difficile (C diff) spores. Reapply as necessary to ensure that the surface remains wet for the entire contact time. 6. Allow surface to air dry and discard used wipe." On 8/21/2019 at 9:18 AM, an observation was conducted of Nurse #1 when she finished a blood sugar check on Resident #117. The nurse took a disinfectant wipe from the container and wiped the glucometer off for 10 seconds and laid the glucometer on top of a clean tissue on the medication cart. In an interview with Nurse #1 immediately following, she stated she would need to let the glucometer dry for 5 minutes, but normally it was dry within a couple of minutes. After reviewing the wipe container instructions which included a "3-minute C diff spore kill time" on the front label, the nurse stated the glucometer was not disinfected according to the wipe package directions. The nurse further stated she had 2 residents on the memory care unit she conducted blood sugar checks on and she cleaned the glucometer as she demonstrated after each resident. On 8/22/2019 at 12:26 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected the nurses to clean the glucometer for 2 minutes with a disinfectant wipe, and then let air dry. The DON stated since they didn't have a resident on the unit with C diff. she would not expect them to wait the full 3 minutes as recommended on the wipe container.	F 880	3. The policy and procedure has been reviewed and no revision is warranted at this time, however the following information has been printed out and placed in the front of each narcotic book on the medication carts: 1) policy and procedure for glucometer use and care 2) manufacturer recommendations for proper sanitizing and 3) QC checklists. This will ensure the nurses have the correct information available at all times. All licensed nursing personnel have been educated by the SDC on the process for properly sanitizing glucometers. Education will be provided at various times on all shifts to ensure all licensed nurses are educated on the proper process for sanitizing glucometers according to wipe manufacturer's recommendations; all education will be completed by September 9, 2019. 4. The D.O.N., A.D.O.N. and SDC will conduct observation audits a minimum of seven (7) times weekly for three (3) months or until sustained compliance is achieved. Assigned nurse managers will observe different nurses on different shifts to ensure correct technique is consistently utilized. Any negative variance will be corrected at the time of observation with education and/or disciplinary action as warranted. A report of audit outcomes will be provided to the QAA Committee for compliance monitoring.	

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