STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 12/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		12/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/20/2019

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family, and staff interview the facility failed to clean the mattress and provide linen for 1 of 5 residents reviewed for clean mattresses/linen (Resident #7). The facility also failed to provide a wheelchair with a back that reclined according to a care plan intervention for 1 of 3 residents reviewed for activities of daily living (Resident #4). Findings included: 1. Resident #7 was admitted to the facility with multiple diagnoses some of which included acute respiratory failure with hypoxia, muscle weakness, sleep apnea, and morbid obesity. The documentation on the most recent quarterly minimum data set assessment dated 11/10/19 coded Resident #7 as cognitively intact and required extensive assistance of one person with bed mobility. An observation and interview were conducted with Resident #7 on 12/6/19 at 10:30 AM. The resident was observed to be laying in a bariatric bed on her back. The mattress for the bed was observed to not have a fitted bottom sheet. The mattress had copious amounts of dried skin flecks and smears of matter on the surface. The resident explained that getting out of the bed was painful, so she was always in the bed. She indicated she attempted to wipe down the mattress when she could but that the facility staff never cleaned the mattress. Resident #7 related she was told by the staff that a fitted bottom sheet	F 584	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. •Resident #7's mattress was cleaned and clean linen was provided by housekeeping manager on 12/18/19. •Resident #4 is no longer a resident at this facility as of 12/6/19 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; •Audit was conducted by housekeeping department to ensure that all resident mattresses are in good condition & clean, and that all linen on resident mattresses properly fit. Any mattresses that needed to be replaced were reported to the administrator and/or maintenance department for further follow up including ordering and replacement of mattresses as necessary. (Audit was completed on 12/18/19). •Current wheelchairs were audited by maintenance director on 12/18/19 to ensure that they are all in proper working condition. (Audit was completed on 12/18/19) 3.Address what measures will be put into place or systemic changes made to	

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F 584	Continued From page 2 for the mattress was not available, but she would like to have one. A simultaneous interview was conducted with a housekeeping staff member (HSM #1) on the hallway for which Resident #7 resided and the environmental services manager (ESM #1) on 12/7/19 at 10:17 AM. HSM #1 explained that every room on the hallway was deep cleaned at least twice a month to include the cleaning of the bed. HSM #1 revealed that if a resident was not able to get out of bed, then the housekeeping staff would clean the rails and bedframe but not the mattress. HSM #1 indicated the nurse aide, assigned to the resident who was unable to get out of bed, would clean the mattress when the sheets on the bed were changed. ESM #1 revealed that the facility had sheets that fit all the beds in the facility to include the bariatric beds. ESM #1 did not know the reasoning behind it, but sheets were never put on the bariatric beds in the facility despite the availability of the sheets. An additional interview was conducted with HSM #1 on 12/7/19 at 10:55 AM. HSM #1 confirmed the mattress of Resident #7 was not cleaned by the housekeeping staff on days when the room was deep cleaned and only the bed frame and rails were cleaned by the housekeeping staff. An additional interview and observation of Resident #7 was conducted on 12/7/19 at 10:58 AM. The resident reiterated she wanted to have a fitted sheet on her mattress because she would sweat a lot sitting on the plastic mattress. Resident #7 indicated the nurse aides did not wipe down the mattress but only changed the folded sheet that was placed under her bottom after an incontinence episode soiled the folded	F 584	ensure that the deficient practice will not recur; •Housekeeping round sheet has been modified to indicate whether or not any resident mattresses and/or wheelchairs are in need of repair or replacement. •Angel rounds tool has been modified to indicate whether any linen was observed on a resident mattress that did not fit •All staff will be inserviced on F 584 and its content and the importance of reporting any equipment that is not properly working and promptly replacing it. Any non working equipment need to be reported to the maintenance director and/or administrator. Additionally, staff was educated on the expectation of the cleanliness of resident mattresses, and the importance of ensuring that all mattress pads properly cover the mattress that it is applied to. Any staff not inserviced on or by 12/18/19 will be educated prior to their next working shift. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; •5 resident mattresses and 5 resident wheelchairs will be inspected weekly X4, monthly X3, and quarterly thereafter by housekeeping manager or designee to ensure that any issues are promptly addressed according to F584 and its content.	

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F 584	Continued From page 3 sheet. The mattress was observed to have dried skin flecks and smears of matter on it. The nurse aide (NA #5) assigned to care for Resident #7 on the 7:00 AM to 3:00 PM shift was interviewed on 12/7/19 at 2:02 PM. NA #5 explained that the facility had sheets for the mattress of Resident #7, but the sheets were difficult to find. NA #5 went to the linen closet and demonstrated the difficulty in finding a sheet to fit the mattress for Resident #7 by unfolding sheets to find a sheet large enough. NA #5 indicated that if a sheet was put on the mattress, it would make the resident slide. NA #5 stated, "It is the job of housekeeping to clean the mattress." The Director of Nursing was interviewed on 12/7/19 at 3:00 PM. The Director of Nursing confirmed the facility had sheets to fit the mattress of Resident #7 and that the nurse aides should put one on the mattress. The Director of Nursing indicated the resident's mattress would be cleaned that day and Resident #7 would be provided with a fitted sheet. 2. Resident #4 was admitted to the facility on 11/30/18 with osteoporosis, lack of coordination and spondylosis. Resident #4 had a care plan updated 10/22/19 in place for falls related to gait/balance problems. An intervention stated, "Recline back of wheelchair for better positioning when sleeping in wheelchair." The resident's quarterly Minimum Data Set dated 11/13/19 revealed the resident was severely cognitively impaired. The resident required extensive assistance with transfers, locomotion,	F 584	•A Summary of monitoring efforts will be completed by Executive Director and presented at the facility monthly QA Meeting for review by the committee members to ensure continued compliance.	

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F 584	Continued From page 4	F 584		

toilet use and personal hygiene. The resident was frequently incontinent of bowel and of urine. The resident used a wheelchair.

A nursing note dated 11/27/19 revealed the resident needed assistance with activities of daily living and was able to propel self in wheelchair.

Nursing Assistant (NA) #1 and NA #2 were observed on 12/5/19 at 11:49 AM to provide care to Resident #4. The resident was transferred to the "guardian" wheelchair with the assistance of 2 NAs. The resident was pivoted to the wheelchair and wheeled to the dining room. The back of the wheelchair was observed in a fixed upright position.

Nursing Assistant (NA) #2 was interviewed on 12/5/18 at 1:48 PM. She stated the resident required total care and could be resistive to care depending on the day. The resident could wheel the wheelchair on her own if she wanted to. NA #2 was asked if the resident's wheelchair was broken. She replied that one of handles on the wheelchair was broken so the back of the wheelchair wouldn't go back all the way. She added that the wheelchair's back had been broken for about 2 weeks.

A wheelchair observation was made on 12/5/19 at 4:15 PM with NA #3. The wheelchair observed was labeled "Guardian" and had a handwritten label that stated "53.8 lbs". The resident was not in the wheelchair at the time of the observation. NA #3 pressed the handles under the handrails on the back of the wheelchair and the left side of the back of the wheelchair would not move the seat up or back and was stuck in a fixed position. When the right handle under the handles was

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F 584	Continued From page 5	F 584		

pressed, the right side of the back of the wheelchair moved freely forward and backwards and then would lock in position when the handle was released. NA #3 stated the "left side wouldn't move forward". NA #3 also stated she didn't know how long the wheelchair had been like this. She stated she would have to ask therapy if this was the resident's (personal) wheelchair as it usually had her name on it.

The resident was observed up to wheelchair on 12/5/19 at 4:39 PM. The resident was sitting outside of her room in the wheelchair. The wheelchair label stated "Guardian" and had a handwritten label that stated "53.8 lbs". The wheelchair had handles to adjust the back of the wheelchair and the back of the wheel was observed in a fixed, upright position.

The resident was observed up to the wheelchair and eating breakfast in the dining room on 12/6/19 at 8:09 AM. The wheelchair label stated "Guardian". A handwritten label on the back of the wheelchair stated "53.8 lbs". The number 62 was labeled on the inside of the wheelchair. The wheelchair had handles to adjust the back of the wheelchair and the back of the wheelchair was observed in a fixed position.

NA #2 was interviewed again on 12/6/19 at 8:37 AM. She stated therapy was working on getting the resident a new wheelchair.

The assistant physical therapist (activities director present) was interviewed on 12/6/19 at 8:44 AM. She stated she didn't know anything about resident #4's wheelchair.

NA # 2 and NA # 4 were observed on 12/6/19 at

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F 584	Continued From page 6	F 584		

11:27 AM providing care to resident #4. The resident was transferred to the bed from the recliner with the assistance of 2 people. The resident was checked for incontinence and then placed in the "Guardian" wheelchair with a handwritten label that stated "53.8 lbs" on the back of it. The back of the wheelchair was in a fixed position. The resident's family was present during the observation. The family asked NA #2 and NA #4 about the broken wheelchair while the resident was being changed. NA #2 responded that therapy was working on it. The resident was placed in the wheelchair and taken to the dining room.

The Resident's family was interviewed on 12/6/19 at 11:56 AM. She stated that one side of the back of the wheelchair was broken. She stated it had been broken for over 1 week. She added that the resident's posture was poor because of it and it caused her to lean to one side when she was in the wheelchair. She stated she kept asking them to fix it and they hadn't.

The resident's family was interviewed again on 12/9/19 at 1:04 PM via phone. The family stated the resident was transferred to another facility in the broken wheelchair on 12/6/19. She stated the wheelchair belonged to the facility and it wasn't an appropriate wheelchair for Resident #4. She also added she had emailed the administrator a few weeks ago about the broken wheelchair and it was never fixed. She stated Resident #4 was at another facility now.

The Administrator was interviewed on 12/6/19 at 3:51 PM (Director of Nursing and corporate consultant present). He stated he never knew the resident's wheelchair was broken. She stated the

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F 584	Continued From page 7 resident's family or staff did not notify him about it. He was surprised (to be told) the wheelchair was not working. They (the facility) did daily rounds and met with the (resident's) family regularly. He would expect for a broken wheelchair to be identified.	F 584		