| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| ACCORDIUS HEALTH AT WILSON | 1804 FOREST HILLS ROAD W WILSON, NC 27893 |

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| E 000 | Initial Comments<br><br>An unannounced COVID-19 Focused Survey was conducted on 07/31/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 5E5A11 | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey, follow up and complaint investigation were conducted on 07/28/2020-07/31/2020. New citiations were cited during this visit, tags F689 and F880.The facility was found out of compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.<br><br>1 of the 20 complaint allegation(s) were substantiated resulting in deficiencies. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews and physician interview, a staff member failed to attach footrests onto a wheelchair prior to transporting a resident in her | F 689 | F689 Free of Accidents Hazards/Supervision /Devices | 8/24/20 |

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

Electronically Signed | 08/21/2020

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| F 689 | Continued From page 1<br>wheelchair and staff instructed the resident to hold her feet up while she was being rolled in her wheelchair for one of one resident (Resident #1) reviewed for accidents.<br><br>Findings included:<br><br>Resident #1 was admitted on 03/19/2019 with diagnoses of generalized muscle weakness, chronic pain, decrease in mobility, muscle wasting and atrophy and left-sided weakness.<br><br>The quarterly Minimum Data Set (MDS) dated 07/06/2020 noted Resident #1 was cognitively intact and needed total assistance for transfers and locomotion on and off unit. The MDS noted impairment of the left upper and lower extremities. Special treatments included occupational therapy three to five times a week through therapeutic activity, Activates of Daily Living (ADLs) self-care management and orthotic management.<br><br>The care plan dated 7/11/2019 noted Resident #1 had an ADL self-care deficit related to limited mobility and weakness. The goal was Resident #1 would receive appropriate staff support for personal hygiene and transfer. Interventions included: Resident #1 was dependent on two staff regarding transfer and locomotion on and off the unit.<br><br>A nursing note dated 7/14/2020 at 2:36 PM, written by Nurse #1, specified Resident #1 complained of left knee pain and she stated it had been throbbing since going to rehab yesterday when her leg went back behind the wheelchair. The Nurse Practitioner was contacted on 7/14/2020 at 2:36 PM and orders were given for | F 689 | What measures did the facility put in place for the resident affected:<br>On 7/13/2020 resident #1 leg had accidentally got up under residents wheelchair during transport to therapy. Per certified occupational therapy; resident denied any pain or discomfort at the time of incident. Responsible Representative notified of incident. On 7/14/2020 resident complained of left knee pain. Assigned Nurse contacted NP Brooke Langley; new order for X-ray of left knee given to assigned nurse. X ray results revealed no fractures or dislocation; Responsible Representative was notified of results by Director of Nursing. On 7/15/2020 Brooke Langley followed up with resident in reference to left knee imaging. NP explained to resident the Xray did reveal chronic osteoarthritis. Resident was given scheduled Tramadol for pain; upon nurse follow up resident stated that the scheduled Tramadol was managing her pain. On 7/20/2020 resident was assessed by Adil Ahmed, MD; new order given for x-ray of residents Left ankle. X ray was negative for Fracture. Responsible Representative was notified of x ray results. On 7/15/2020 Administrator and Director of Rehab in serviced the Certified Occupational Therapist Assistant to always apply leg rest if resident is unable to utilize lower extremity during transport and to honor all residents request.<br><br>What measures were put in place for residents having the potential to be | |

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| F 689 | Continued From page 2<br>x-ray of left knee.<br><br>A radiology report dated 7/14/2020 at 8:41 PM revealed Resident #1 ' s knee joint was in alignment and no acute fractures or dislocation were noted.<br><br>Physician orders written on 7/15/2020 at 2:48 PM for Resident #1 specified for staff to apply icepacks for 10 minutes as needed to left knee for 48 hours for swelling and pain. Resident #1 was on scheduled tramadol 50mg twice daily for chronic pain and received all scheduled doses as ordered during the look back period.<br><br>An interview with Resident #1 on 7/28/2020 at 10:45 AM, revealed on 7/13/2020 an Occupational Therapy Assistant (OTA) entered her room to take her to therapy. Resident #1 stated she was sitting in a wheelchair without footrests and the OTA asked her to hold her right leg up with the left leg resting on it and she then began pushing her wheelchair. Resident #1 stated she asked the OTA to attach the wheelchair ' s footrests, but the OTA stated she would return to get the footrests for the resident ' s return trip after her therapy session. The resident explained during the transport to the therapy gym, her left leg fell off her right leg and went under one of the wheelchair ' s wheels. Resident #1 stated she yelled "ouch" and asked the OTA to please stop the wheelchair. Resident #1 stated the OTA stopped the wheelchair, propped her left leg onto her right leg and proceeded to roll her in her wheelchair the rest of the way to the gym. Resident #1 stated she completed the therapy session, the OTA retrieved the wheelchair footrests, attached them and rolled her in her wheelchair back to her room. | F 689 | affected:<br>Residents will be re evaluated to see if footrest are required during transporting by Director of Rehab to be completed by 8/17/2020. Residents care plans will be updated by the Minimum Data Set Nurse to ensure each resident have the appropriate interventions in place for footrest if needed. New residents admitting to the facility will be screened for assistive devices such as leg rest. To be completed by 8/25/2020. Any deficiencies found will be corrected immediately. Minimum Data Set nurse will report all findings to the Director of Nursing and the Administrator immediately.<br><br>What systems were put in place to prevent the deficient practice from reoccurring:<br>On 8/17/2020 In-service was initiated by the Staff Development Coordinator on: If you feel like you need any extra equipment for safe transportation of a patient, please let the DON or PT know before you start to move the patient. THINK SAFTEY FIRST When you are transporting a patient in a wheelchair ALWAYS tell them what you are going to do before you do it. Before transporting the patient, you need to unlock the wheels and make sure the footrest is in a safe position for the patient’s legs. ALL patients that require footrest MUST use them when you are transporting. If a patient requests footrests or any other type of equipment to be transported, we NEED to make sure we are honoring the patients wishes at ALL times. It’s important that | |

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| F 689 | Continued From page 3<br>She stated she did not experience any pain during her therapy session on 7/13/20, but noticed the pain the following day. She explained she experienced swelling and pain to her left knee for about a week after the incident and received ice packs and medication for the pain.<br><br>An interview with the OTA on 7/29/2020 at on the day of 7/13/2020 around 1:20 PM, she entered Resident #1 ' s room to take her to the gym for her occupational therapy treatment. Resident #1 was sitting in her wheelchair when she arrived. She stated she put Resident #1 ' s left foot onto her right foot as support and she began pushing the resident ' s wheelchair. She stated Resident #1 asked her to attach the wheelchair ' s footrests, but she didn ' t attach the footrests. The OTA stated she wasn ' t sure why she chose not to attach the footrests other than she thought Resident #1 could make it all the way to gym holding her feet up. She stated as they approached the lobby of the facility, Resident #1 ' s left foot fell from her right foot and her left foot went under the wheel of the wheelchair. She stated Resident #1 yelled, "ouch", and she stopped the wheelchair and looked at her foot and didn ' t see any apparent injury. She stated she placed the resident ' s left foot onto her right foot and proceeded to roll the resident in her wheelchair to the gym for therapy. She stated she went to Resident #1 ' s room to retrieve the wheelchair footrests and attached them to her wheelchair for the return trip to her room.<br><br>Interview with an Occupational Therapist on 7/28/2020 at 1:15 PM revealed he began working with Resident #1 on 7/14/2020, one day after the wheelchair incident occurred. He stated he only worked with her upper body and she experienced | F 689 | you stop and look to make sure their legs are position correctly and will not fall off while moving. Keep an eye on all their limbs to make sure they stay in the correct position. You never want to pull a wheelchair backwards with the patient in it. ALWAYS push them facing forward. To be completed by 8/24/2020.<br><br>How the facility will monitor systems put in place:<br>Staff Development Coordinator/Director of Nursing/Director of Rehab will audit 5 resident transfers weekly using the transfer audit tool to ensure footrest are being used during transports; if needed. 5 resident transfers will be audited weekly x 4 weeks, then 5 resident transfers monthly to include x 2 months.<br><br>The DON /Administrator will present all findings from the transfer audit tool at the monthly QI committee. The monthly QI committee will review the results of the MDS completion audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. | |

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| F 689 | Continued From page 4 | F 689 | | |

no pain during his session with her over the next few days after the incident.

Interview with a Nurse #1 on 7/29/2020 at 7:35 PM revealed she worked with Resident #1 on 7/13/2020, during the 3:00 PM to 11:00 PM shift, and was not informed by Resident #1 of pain or swelling after she returned from her therapy session. The nurse stated she did not remember if the OTA informed her of the incident of Resident #1 ' s left leg going under the wheelchair when they returned from therapy on 7/13/2020. She stated her interactions with Resident # 1 on 07/13/2020, were pleasant for the remainder of her shift.

Interview with a Nurse #2 on 7/30/2020 at 8:47 AM revealed Resident #1 complained of pain and swelling to her knee during the 7:00 AM to 3:00 PM shift on 7/14/2020. Nurse #2 stated she assessed Resident #1 and observed swelling and slight bruising to her left knee. Nurse # 2 contacted the Nurse Practitioner and obtained an order for left knee x-ray.

Interview with the facility physician on 7/31/2020 at 10:02 AM revealed he assessed Resident # 1 on 7/21/2020 at 8:39 AM and observed slight swelling to Resident #1's left ankle and ordered an x-ray, Voltaren gel 1% to be applied twice a day for pain and acetaminophen 650 mg tablets every 6 hours as needed for left leg pain. An x-ray was completed on 7/21/2020 and revealed there were no fractures or dislocation to Resident #1 's left ankle or foot.

Interview with the Director of Nursing on 7/31/2020 at 10:49 AM revealed the facility procedure for safe resident transport was to

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| F 689 | Continued From page 5<br>attach footrests to wheelchairs prior to transport.<br><br>Interview with the Administrator on 7/31/2020 at 11:25 AM revealed the proper facility practice to transport a resident safely by wheelchair was to attach the footrests to the resident 's wheelchair each time prior to transporting the resident. | F 689 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or | F 880 | | 8/25/20 |

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| F 880 | Continued From page 6<br>infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and review of the facility's infection control and | F 880 | Accordius Health at Wilson<br>Directed Plan of Correction (DPOC): PPE | |

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| F 880 | Continued From page 7<br>COVID-19 policies, the facility failed to implement their COVID-19 screening policy by not screening 1 of 1 visitors upon entrance to the facility. The facility also failed to implement their COVID-19 policy for face masks to be worn at all times when a personal care aide did not wear a facemask while passing ice and entered the rooms of 2 of 2 residents (Residents #2 and #3). These failures occurred during the COVID-19 pandemic.<br><br>The findings included:<br><br>1. The facility's "COVID-19 Policy/Plan for Facilities" updated on 5/26/2020 stated all venders, providers, and visitors permitted into the building were to follow all screening processes: sign in and out on the log, check temperature, screen and use hand hygiene at entrance and exit.<br><br>On 7/28/20 at 8:18 pm, Nurse #5 unlocked the front door of the facility and permitted a surveyor to enter the building. When the surveyor entered the facility, Nurse #5 did not perform any of the facility's COVID-19 screening processes on the surveyor. Nurse #5 was observed to walk by the receptionist desk in the front lobby, where the facility conducted its COVID-19 screening, and only asked if the surveyor needed to get into the conference room. When the surveyor informed Nurse #5, that she would be at the nurse's station, Nurse #5 proceeded out of the front lobby area and down the left hallway.<br><br>On 7/28/20 at 8:20 pm, Nurse #5 was observed standing at the B-Hall medication cart. Nurse #5 informed the surveyor there was no supervisor in the building. When Nurse #5 was informed the surveyor planned to visit with residents, Nurse #5 | F 880 | (not wearing Mask), Failure to Screen Visitor<br>Root Cause Analysis (RCA)<br><br>Identify the root cause resulting in the facilities failure:<br>A thorough analysis of contributing factors which lead to identifying the root cause regarding the failure to screen a visitor upon entrance to the facility/Personal Care Aide not wearing a face Mask was conducted. The internal investigation included:<br>" Interviews with the PCA #2 and Nurse#5 identified in the 2567<br>" The completion of the 5 WHYS WORKSHEET in collaboration with the QAPI Committee (attached)<br>The analysis concluded the root cause is:<br>Staffing is challenged, particularly of nursing management staff i.e. the SDC/ICP who is responsible for the implementation and maintenance of re-education and competency regarding wearing a Mask and proper screening of employee and visitors.<br>The corrective action:<br>Nurse #5 was reeducated on 8/17/2020 by the Nursing Home Administrator on the proper procedure for screening visitors upon entrance to the facility. Personal Care Aide #2 was termed for failure to wear a mask while in the facility.<br>Identification of other residents in the facility who may need to be included:<br>On 8/16/2020, staff present in the building to include Administrative, Dietary, Rehab, housekeeping, and nursing working in the facility were visually | |

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| F 880 | Continued From page 8<br>did not offer to screen the surveyor.<br><br>On 7/28/20 at 8:50 pm, an interview was conducted with Nurse #5. When Nurse #5 was asked, "what was the facility's screening process," Nurse #5 stated "I know, I didn't screen you when you came in. I forgot. Do I need to screen you now?" Without the surveyor answering the question, Nurse #5 directed the surveyor to the front lobby receptionist desk to conduct the COVID-19 screening: checked temperature, asked the screening questions and recorded information and time in the building on the visitor log.<br><br>On 7/30/20 at 1:05 pm, during a phone interview, Nurse #5 stated someone was scheduled at the receptionist desk to screen employees and visitors until 8:00pm. Nurse #5 stated after 8:00pm the nursing staff were responsible for screening the visitors and were trained to conduct the screening process for visitors the same way the staff were screened.<br><br>The Director of Nursing (DON) was interviewed on 7/28/20 at 10:37pm. The DON stated the screening log was completed on all persons entering the building which included a temperature check and the screening questions.<br><br>During a follow up phone interview with the DON on 7/31/20 at 12:57pm, the DON stated all staff and visitors entered through the front door and were to be screened. The DON stated the screening process started in March 2020, and all staff had received training on the screening process. The DON stated after 8:00pm, the person unlocking the door was responsible to screen the visitor. | F 880 | observed to ensure all mask were on and worn properly by the Admissions Coordinator, Staff Development Coordinator, and Director of Nursing. Nursing Home Administrator, Admissions Coordinator, Director of Rehab visually observed receptionist screen employees and visitors to ensure facility policy and procedure for COVID 19 was being followed. This is to ensure all residents and staff remain safe. All staff were in compliance.<br>Solutions and systemic changes that need to be taken to address the root cause:<br>1. On 8/17/2020 the Staff Development Coordinator started re-education to the current facility staff on COVID 19 policy to include using the CMS recommended KEEP COVD 19 OUT! YouTube video. The Director of Nursing/Staff Development Coordinator will continue the education which will be completed by 8/25/2020. This education will be a part of new staff orientation.<br>2. The Nursing Home Administrator/Director of Nursing recruited and hired the following nursing management positions. Under the Director of Nursing□s leadership, this team will be responsible for the implementation and maintenance of re-education and competency regarding Face Mask and Properly screening visitors and employees:<br>¿ Staff Development Coordinator/Infection Control Preventionist □ started 7/06/2020<br>3. On 8/16/2020, Staff Development Coordinator/Director of | |

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| F 880 | Continued From page 9<br><br>During a phone interview on 7/21/20 at 1:43 pm, the Administrator stated all staff and visitors were to be screened entering the facility and after 8:00pm, the nursing staff were responsible for screening persons entering the building.<br><br>2. The facility's "COVID-19 Policy/Plan for Facilities" updated on 5/26/2020 stated all staff will be required to wear a surgical or isolation mask at all times in the facility.<br><br>On 7/28/20 at 8:32 pm, Personal Care Aide (PCA) #2 was observed not wearing a face mask and entered Resident #2's room carrying a cup of ice. PCA #2's nose and mouth were not covered. Resident #2 was observed in bed and the PCA placed the cup of ice on the resident's bedside table.<br><br>On 7 /28/20 at 8:35 pm, Personal Care Aide #2 was observed in Resident #3's room and she was not wearing a face mask. PCA #2's nose and mouth were uncovered. Resident #3 was observed in bed and the PCA placed the cup of ice on the resident's bedside table.<br><br>On 7/28/20 at 8:38 pm, Personal Care Aide #2 was observed in the hallway with an ice container wearing no facial covering and an interview was conducted. Personal Care Aide #2 stated she received COVID training in orientation and was informed staff were to wear a facial mask at all times in the facility. Personal Care Aide #2 stated she had just finished eating and forgot to reapply her mask. Personal Care Aide #2 reached into her right shirt pocket of her uniform and applied a face mask covering the nose and mouth. | F 880 | Nursing/Administrative staff (Admissions Coordinator, Medical Records, Director of Rehab, and Social worker) initiated a Screening and PPE audit. Facility will observe 10 employees per audit daily times 5 days, weekly times 3 weeks, bi-weekly times 2 weeks and then monthly times 1 to ensure facility staff are properly wearing masks at all times and screening all employees and visitors utilizing PPE and Employee Visitor screening audit tool.<br>The Staff Development Coordinator/Director of Nursing/Administrative staff (Admissions Coordinator, Assistant Business Office Manager, Medical Records, Director of Rehab, and Social worker) will continue the audits.<br>Monitoring of approaches to ensure infections are controlled going forward:<br>The Nursing Home Administrator will review the results of the observational Employee/Visitor Screening/PPE audits daily times 5 days, weekly times 3 weeks, bi-weekly times 2 and monthly times 1 to ensure (PPE) are properly worn at all times and Facility is properly screening employees and/or visitors. Findings will be reported monthly to the QAPI team for review times 3 months. The QAPI Committee can modify this plan to ensure the facility remains in compliance. Documentation of the review will be kept by the Administrator in the QAPI Book.<br>Completion date: August 25, 2020<br><br>5 WHYs Worksheet<br>Accordius Health at Wilson<br>Root Cause Analysis (RCA): Infection | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345063 | A. BUILDING _____ B. WING _____ | C 07/31/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT WILSON | 1804 FOREST HILLS ROAD W WILSON, NC 27893 |

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| F 880 | Continued From page 10<br>The Director of Nursing (DON) was interviewed on 7/28/20 at 10:37 pm. The DON stated staff were to wear a facial mask at all times while in the building.<br><br>During a phone interview with the Administrator on 7/31/20 at 1:43 pm, the administrator stated the personal protective equipment requirement of the facility was for all staff to wear a face mask properly at all times in the facility. | F 880 | Control □ PPE/Screening Employees/Visitors<br>Define the Problem:<br>Nurse #5 and Personal Care Aide #2 failed to wear PPE while in the facility and screen a visitor upon entering the facility<br><br>Why is it happening? (Identify each as a concern, influence or control.)<br><br>1. Interviews with PCA #2 and NURSE #5 demonstrated they both had been trained on properly screening of employees and PPE, but their concentration was on the tasks at hand and they forgot. Why is that?<br><br>2. There is a lack of re-education and competency demonstration of PPE and Screening process. Why is that?<br><br>3. There is not a designated staff member(s) to implement and maintain a re-education and competency demonstration of PPE (wearing Mask) and Screening of visitors Why is that?<br><br>4. The Staffing Development Coordinator/Infection Control Preventionist position was recently filled. | |

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| F 880 | Continued From page 11 | F 880 | Why is that?<br><br>5. Staffing is challenged, particularly of nursing management staff i.e. the SDC/ICP who is responsible for the implementation and maintenance of re-education and competency regarding wearing mask at all times and properly screening visitors upon entrance into the facility. Why is that?<br><br>Caution: If your last answer is something you cannot control go back up to previous answer.<br><br>*(Provided as a free template by The IPL LLC) | |