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 09/09/2020

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 COVID-19 Focused Survey was conducted on 9/02/20 through 9/09/20. 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# MF1C11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 9/02/20 through 9/09/20. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations resulting in Federal Citation F880. Four of the six complaint allegations were substantiated resulting in deficiencies. Event ID #MF1C11.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		10/3/20

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

Electronically Signed | 09/25/2020

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 09/09/2020

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 585	Continued From page 1	F 585		

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as

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 09/09/2020

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 585	Continued From page 2 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to make prompt efforts to resolve grievances for 1 of 3 residents sampled for	F 585	The Administrator and the Social Worker addressed the Resident concern form for 7/28/2020 on 9/18/20 with resolution 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 09/09/2020

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 585	Continued From page 3 grievances (Resident #11). The findings included: Resident #11 was admitted to the facility on 12/28/18 with diagnoses that included dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 7/16/20 revealed Resident #11 had severe cognitive impairment. Review of grievances revealed a grievance filed on behalf of Resident #11 dated 7/28/20. The grievance indicated concerns related to weight loss, hair loss and the facility's failure to communicate changes to the family. There was no investigation noted on the grievance report nor resolution communicated to the resident or family. An interview was conducted with the Regional Director of Operations on 9/2/20 at 12:30 PM who stated the former Administrator was the grievance official. She stated it was the former Administrator's responsibility to ensure grievances were investigated and resolution was communicated to the responsible party. The Regional Director of Operations stated she did not know why this grievance for Resident #11 was not investigated. An interview was conducted with the Director of Nursing on 9/2/20 at 1:46 PM who stated she had no contact with Resident #11's family regarding a grievance. An interview was conducted with the Social Work Assistant on 9/3/20 at 11:12 AM who stated she was aware the Social Worker took the grievance	F 585	follow up with the resident and Responsible Party (RP) on 9/18/20. An audit of all resident concerns to include resident #11, for the past 30 days, were reviewed by the Administrator on 9/18/20 to ensure all resident concerns were completed with appropriately with timely resolution and followed up with the Resident/Family/Representative who filed the grievance. Any concerns identified, were addressed with appropriate resolution and follow up during the audit by Social Services Director. In-service was conducted on 9/18/2020 by the administrator for department managers utilizing the policy and procedure for the grievance process to include appropriate timely resolution and follow up with the Resident/Family/Representative who filed the grievance, and in-servicing was initiated by Unit manager with licensed nurse staff and non-clinical staff regarding the grievance process to be completed by 10/3/2020. Newly hired employees will be educated during orientation regarding the facility Grievance process to include resident concerns are documented on the appropriate forms when received and notification to the appropriate department Manager of the concern. Resident concerns will be brought to the daily clinical meeting by the department manager who received the concern. Resident concern forms, to include any concerns for resident #11, will be reviewed to ensure all concerns were completed timely, appropriate resolution	

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 09/09/2020

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 585	Continued From page 4 from a family member. She stated she recalled that this grievance was brought up in the daily morning meeting but was unsure of any investigation completed for the grievance. The Social Worker was unavailable for interview.	F 585	and timely follow up with the Resident/Family/Representative. A Grievance Resolution QI tool to be completed by the Social Service Director 3X a week X 4 weeks, weekly X 4 weeks, then monthly for 1 month The Administrator or designee will review and initial the Grievance Resolution QI tool weekly X 12 weeks for completion and will complete retraining with the appropriate department manager for any identified areas of concern. The Executive QI Committee will meet monthly and review the Grievance Resolution Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		10/3/20

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 09/09/2020

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 657	Continued From page 5 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to invite the resident representative to the care plan conference for 1 of 3 sampled residents (Resident #11). The findings included: Resident #11 was admitted to the facility on 12/28/18 with diagnoses that included dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 7/16/20 revealed Resident #11 had severe cognitive impairment. The medical record revealed no interdisplinary care conference was held since 4/28/20. An interview was conducted with the Social Work Assistant on 9/2/20 at 11:12 AM who stated the social work department invited residents or resident representatives to care conferences. She stated that since March 2020 care plan conferences were held over the phone. The Social Work Assistant stated Resident #11 had not had a care plan conference since 4/28/20. She reported that a care plan conference should have been conducted.	F 657	On 9/3/2020, the MDS nurse conducted and held a multidisciplinary care conference with the resident #11□s responsible party at 14:05. Current or newly admitted residents have the potential to be affected. The MDS consultant or MDS nurse completed a 100 % audit to ensure interdisciplinary care conferences were conducted timely with Resident and resident representatives, as well as, documented in the medical record. Any care conferences that need to be conducted by MDS and the interdisciplinary team will be completed by 10/3/2020. Interdisciplinary Team was educated regarding the scheduling and conducting of care conferences in a timely manner by the Administrator/DON. The Director of Nursing or designee shall audit 5 resident records weekly for 12 weeks to ensure that interdisciplinary care conferences are scheduled and occur with documentation in the medical record. The Director of Nursing or MDS Nurse will report findings monthly for three months	

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 09/09/2020

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 657	Continued From page 6 An interview was conducted with MDS Nurse #1 on 9/2/20 at 11:40 AM who stated the care conference was not completed and it must have been an oversight. She reported she would contact the resident representative to conduct a care conference. During an interview with the Regional Director of Operations on 9/2/20 at 1:32 PM she indicated the care plan conference for Resident #11 should have been conducted quarterly.	F 657	during the QAPI meetings for review and further recommendations.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and	F 692	Resident #11□s Registered Dietician	10/3/20

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 09/09/2020

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 692	Continued From page 7 physician interviews the facility failed to prevent weight loss for 1 of 1 resident reviewed for weight loss (Resident #11). The findings included: Resident #11 was admitted to the facility on 12/28/18 with diagnoses that included dementia. A nutrition note dated 6/26/20, written by the facility ' s Registered Dietitian (RD), revealed a recommendation for Resident #11 to receive a frozen supplement each day to increase calorie intake. The quarterly Minimum Data Set (MDS) assessment dated 7/16/20 revealed Resident #11 had severe cognitive impairment and had experienced weight loss. A nutrition note dated 7/17/20, written by the facility ' s RD, revealed a recommendation for Resident #11 to receive a frozen supplement each day to increase calorie intake and noted it was a previous recommendation. Resident #11 ' s care plan, most recently reviewed on 7/20/20 identified: weight loss due to poor appetite and intake. Approaches to this problem included registered dietician to evaluate and make diet change recommendations as needed. Resident #11 ' s weight record from May 07, 2020 to August 06, 2020 revealed the resident had experienced the following weight loss: 05/07/20: 120 pounds 06/11/20: 117 pounds 07/07/20: 112 pounds	F 692	(RD) recommendations were reviewed for the past 30 days. Physician reviewed and implemented as ordered. An audit of current residents RD recommendations for the past 30 days was completed to ensure that the recommendations had been reviewed by the physician and implemented as ordered. Nurse managers were educated regarding the review and implementation of RD recommendations in a timely manner by the DON. This in-service should conclude on 10/3/20. This in-service will be part of the orientation for new licensed nursing staff, including agency. The DON and/or designee will audit 10 resident RD recommendations to ensure the timely physician review and implementation weekly for 12 weeks. The results of the audits will be presented at the monthly QAPI committee meeting for review and further recommendations	

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 09/09/2020

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 692	Continued From page 8 08/06/20: 110 pounds A nutrition note dated 8/13/20 written by the facility ' s RD, revealed a recommendation for for Resident #11 to receive a frozen supplement each day to increase calorie intake and noted it was a previous recommendation. An interview was conducted on 09/03/20 at 2:54 PM, with the facility ' s Registered Dietitian who made previous recommendations for Resident #11 to have a frozen nutritional supplement daily. The RD reported that she had been providing consultation remotely to the facility since May 2020. The Registered Dietician stated she made recommendations and would email them to the Director of Nursing (DON). She indicated Resident #11 ' s name sounded familiar but could not recall the situation. The Registered Dietician stated that she had no contact with the physician and the DON was responsible for speaking with the doctor about her recommendations. An interview was completed with the facility ' s former Director of Nursing (DON) on 9/4/20 at 1:28 PM. She stated that when the Registered Dietician made recommendations they would be sent to her via email. She reported that she did not have an opportunity to take the recommendations and speak with the doctor. She reported she was the only person in the facility getting the dietary recommendations and she didn ' t have time because of staffing. The former DON stated she frequently had to work on a medication cart and the RD ' s recommendations were not addressed. An interview was conducted with the facility ' s current Director of Nursing on 9/4/20 at 1:53 PM.	F 692		

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 09/09/2020

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 692	Continued From page 9 The current DON stated dietary recommendations should be reviewed and addressed by the DON or designee. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He stated he was aware Resident #11 had lost weight in the past but not recently. He reported the facility had not contacted him regarding adding a frozen supplement for Resident #11. The Medical Director stated the facility would not need to contact him to add a frozen supplement to Resident #11 ' s diet if recommended by the Registered Dietician.	F 692		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced	F 712		10/3/20

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 09/09/2020

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 712	Continued From page 10 by: Based on record review, staff interviews, and physician interviews the facility failed to ensure physician visits were performed every sixty days as required for 2 of 3 sampled residents reviewed for physician services (Resident #1 and Resident #11). The findings included: 1. Resident #1 was admitted to the facility on 7/1/19 with diagnoses that included hypertension and chronic obstructive pulmonary disease. The medical record revealed physician progress notes dated 2/12/20 and 7/22/20 and nurse practitioner notes dated 7/13/20 and 7/15/20. During an interview on 9/3/20 at 1:45 PM the Regional Vice President stated the nurse practitioner was not submitting her notes, so she was terminated from the facility approximately the first week of April. She further stated the current medical director is in the facility frequently seeing patients but may not be documenting visits. During an interview on 9/9/20 at 8:01 AM the Director of Nursing reported the medical records director was responsible for scheduling doctor ' s visits and ensuring the provider ' s note was uploaded into the chart. She indicated Resident #1 should have been seen by a provider between 2/12/20 and 7/13/20 and the notes filed in the electronic medical record. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He indicated Resident #1 was now being seeing by a provider in his practice and was seen previously by	F 712	Resident 11 no longer in the facility. Resident 1 was seen by the physician by 9/25/2020. 100% audit of current resident physician visits for the past 30 days, were reviewed by the Medical Records Manager on 9/16/20. The Medical Director was also contacted on 9/16/20 to alert the physician of missed visits. Any resident in need of a physician visit will have a visit and note completed by 10/3/2020. The Medical Records Manager or designee will monitor 10 resident medical records weekly x 12 weeks to ensure physician visits are conducted timely. The QA committee will monitor the results for 3 months and determine the need for continued monitoring. The DON or designee will present the findings to the QA committee for further oversight.	

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 09/09/2020

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 712	Continued From page 11 another provider. 2. Resident #11 was admitted to the facility on 12/28/18 with diagnoses that included dementia and hypertension. The medical record revealed the most recent physician progress notes were dated 3/18/20 and the most recent nurse practitioner notes were dated 12/20/19 and 3/19/20. During an interview on 9/3/20 at 1:45 PM the Regional Vice President stated the nurse practitioner was not submitting her notes, so she was terminated from the facility approximately the first week of April. She further stated the current medical director is in the facility frequently seeing patients but may not be documenting visits. During an interview on 9/9/20 at 8:01 AM the Director of Nursing reported the medical records director was responsible for scheduling doctor 's visits and ensuring the provider''s note was uploaded into the chart. She indicated Resident #11 should have been seen by a provider since 3/19/20 and filed into the electronic medical record. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He indicated Resident #11 was his patient. He stated that he did not recall the last time he saw Resident #11 and she may have been seen by another provider in his practice.	F 712		
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.	F 756		10/3/20

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 09/09/2020

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 756	Continued From page 12 §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. §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, staff interviews and	F 756	Pharmacy recommendations for resident	

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 09/09/2020

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 756	Continued From page 13 physician interview the facility failed to ensure the physician reviewed pharmacy recommendations and documented any action taken or a rationale for no action taken on the pharmacy request for 1 of 1 resident reviewed for drug regimen review (Resident #11). The findings included: Resident #11 was admitted to the facility on 12/28/18 with diagnoses that included dementia and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 7/16/20 revealed Resident #11 had severe cognitive impairment. Review of Resident #11 ' s orders revealed on 12/21/19 she was ordered Mirtazapine 15 milligrams by mouth at bedtime for depression. Resident #11 was ordered Lorazepam .5 milligrams as needed for acute anxiety and agitation on 5/20/20 with an indefinite end date. Resident #11 last received Miratzapine 15 milligrams on 9/6/20 and Lorazepam .5 milligrams on 8/23/20. Record review revealed a consultant pharmacy report dated 6/11/20 with a recommendation to consider a dose reduction of Mirtazapine to 7.5 milligrams from 15 milligrams. There was no documentation of any action taken or a rationale for no action taken. Record review revealed a consultant pharmacy report dated 7/9/20 with a recommendation to either discontinue the as needed order for Lorazepam or indicate a stop date for the medication. There was no documentation of any action taken or a rationale for no action.	F 756	#11 were audited and presented to physician if not previously address. An audit of current residents pharmacy recommendations for past three months was completed to identify any recommendations not addressed by the physician. The physician reviewed any that were identified. Nurse managers were in-serviced regarding the timely review of pharmacy recommendations by the physician and appropriate follow-up by the DON/designee and will be completed by 10/3/2020.The monthly pharmacy recommendations will be audited by the DON for three months to ensure that the physician has reviewed timely and recommendations implemented as appropriate. The results of the audit will be presented to the QAPI committee for review and recommendations for a minimum of three months.	

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 09/09/2020

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 756	Continued From page 14 Record review revealed a consultant pharmacy report dated 8/7/20 with a recommendation to either discontinue the as needed order for Lorazepam or indicate a stop date for the medication. An interview was completed with the former Director of Nursing on 9/4/20 at 1:28 PM. She indicated the monthly consultant pharmacy reports were sent to her via email. She reported that she did not have an opportunity to take the recommendations and speak with the doctor. She reported she was the only person in the facility getting these reports and she didn ' t have time to follow-up on these reports because of staffing. The former DON stated she frequently had to work on a medication cart and the pharmacy recommendations were not addressed. An interview was conducted with the current Director of Nursing on 9/4/20 at 1:53 PM who stated the consultant pharmacy recommendations should be reviewed and addressed by the DON or designee. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He indicated he was not aware of any consultant pharmacy recommendations. The Medical Director stated he was unaware that Resident #11 was taking as needed Lorazepam as that is not a drug he utilized.	F 756		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		10/3/20

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 09/09/2020

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 880	Continued From page 15	F 880		

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 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

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 09/09/2020

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 880	Continued From page 16 (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 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 observations, record review, resident, staff, and physician interview, the facility failed to monitor resident vital signs according to Centers for Disease Control and Prevention (CDC) guidelines, post signage related to Coronavirus disease 2019 (COVID-19), ensure hand hygiene was performed by staff and visitors during entrance screening process, cancel resident's group activities, and notify cognitively intact residents who were their own responsible party of COVID-19 test results. (Resident #2, #4, #6, #9, and #10) This failure occurred during a COVID-19 pandemic.	F 880	Vital signs 1. Resident #4 and #6 are no longer at the facility. Resident #2 orders were reviewed and updated to reflect the appropriate frequency for monitoring of vital signs. 2. A 100% audit was completed of residents vital sign orders to ensure the appropriate frequency was ordered and documented. 3. 9/16/20 Nursing staff was in-serviced regarding the correct frequency for which vital signs were to be taken and documented for Covid-19 positive	

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 09/09/2020

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 880	Continued From page 17 Findings included: 1. Per CDC guidelines titled Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20 read in part "Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections." Per CDC guidelines titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 7/15/20 read in part "While screening should be performed upon entry to the facility, it should also be incorporated into daily assessments of all admitted patients." The facility's COVID Response Plan updated 9/02/20 read in part "COVID positive or exposed, isolated residents are monitored very close for change in condition that may warrant hospitalization. Moved to every 4 hours vitals and SPO2 (oxygen saturation)." The facility's COVID Response Plan updated 9/02/20 read in part "All residents in center receiving every shift temperature monitoring, SPO2 every shift, and respiratory surveillance daily." a. Resident #4: Record review of Resident #4 revealed she was sent to the hospital on 8/18/20 and returned to the facility from the hospital on 8/25/20 and died on 8/28/20. During that time documentation revealed her temperature and oxygen saturation	F 880	residents, the proper respiratory template, and all correct template and frequency for non Covid residents, and signs and symptoms of decline. by the DON or designee. This should be completed by 10/3/2020 and ongoing as necessary. 4. DON or designee will complete audits of 5 residents vital signs to insure they have been acquired and documented per orders and documented. The audits will be completed 5 times a week for 2 weeks then 3 times a week for 10 weeks 5. The results of the audits will be presented at the monthly QAPI committee meeting and further recommendations for a minimum of three months. Signage 1. All signage related to Covid 19 was immediately posted on the main entrance door, West Annex entrance (Covid-19 positive). 2. Staff was educated regarding the posting of appropriate Covid-19 signage by the Administrator/designee. 3. The Administrator/designee will audit the presence of appropriate signage (main entrance and West Annex. The audit will be completed 5 times a week for 1 week, three times a week for three weeks, and weekly for two months. 4. The results of the audits will be presented at the monthly QAPI committee meeting and further recommendations for a minimum of three months. Cancel Group Activities All group activities were immediately stopped. Department managers were educated by the Administrator	

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 09/09/2020

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 880	Continued From page 18 had been taken on 8/25/20 at 9:19 PM and 8/27/20 at 2:02 PM. Resident #4 tested negative for COVID-19 at the facility on 8/06/20 and positive for COVID-19 at the hospital on 8/18/20. Record review of progress notes and assessment records reveal no documentation of a respiratory assessment in the month of August. An interview with Nursing Assistant (NA) #1 on 9/03/20 at 2:15 PM revealed she had worked some of the day and evening shifts on the COVID-19 unit between 8/25/20 and 8/28/20 and had provided care to Resident #4. She stated the nurse had told her "not to worry about taking Resident #4's vital signs" which she understood to mean the nurse would take them. An interview with NA #2 on 9/03/20 at 3:15 PM revealed she worked some of the evening shifts on the COVID-19 unit between 8/25/20 and 8/28/20 and had provided care to Resident #4. She stated she didn't remember if she had taken her vital signs or not but if she had taken them she would have documented them in the computer. She further stated the nurse had probably taken Resident #4's vital signs. An interview with Nurse #3 on 9/04/20 at 12:05 PM revealed she had worked on the COVID-19 unit at least one day between 8/25/20 and 8/28/20. She stated she did not take Resident's #4's vital signs because there was no order for her to do so. Attempts to contact the agency staffing nurse on duty on 8/28/20 when Resident #4 died were	F 880	regarding no group activities. Administrator will complete a weekly attestation that no group activities have occurred. These attestations will be presented at the QAPI meeting for approval for 3 months. Hand Hygiene Staff responsible for performing the entrance screening process of staff and visitors were educated regarding performance for hand hygiene (use of hand sanitizer) upon entry by the Administrator or DON. The Administrator and/or designee will use the PPE audit tool to monitor the entrance screening process 5 times a week to ensure hand hygiene is accomplished for a period of two weeks, and randomly three times a week for ten weeks. The results of the audits will be presented at the monthly QAPI committee meeting for further recommendations for a minimum of three months. Reporting Covid Results 1. Residents #4 and #6 are no longer at the facility. Residents #2, #9 and # 10 were given their Covid 19 test results 2. An Audit of all cognitively intact residents was completed to insure they had/have been notified of their last Covid 19 test results. 3. 9/22/2020, the DON or designee will obtain covid-19 test samples from our negative residents and or those who have met the 90-day requirements. DON/designee will test the resident based on CDC and facility policy and procedure	

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 09/09/2020

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 880	Continued From page 19 unsuccessful. b. Resident #2: Record review of Resident #2 revealed she was sent to the hospital for evaluation on 8/24/20 and returned to the facility on 8/24/20. Resident #2 tested negative for COVID-19 at the facility on 8/06/20 and positive for COVID-19 at the hospital on 8/24/20. Record review revealed Resident #2's temperature had been taken 5 times in the month of August. Twice on 8/21/20 and daily on 8/25/20, 8/26/20, and 8/27/20. Record review revealed Resident #2's oxygen saturation had been taken once in the month of August on 8/27/20. Record review of progress notes and assessment records reveal no documentation of a respiratory assessment in the month of August. c. Resident #6: Resident #6 tested negative for COVID-19 at the facility on 8/06/20 and tested positive for COVID-19 at the hospital. Record review of Resident #6 revealed he was sent to the hospital for evaluation on 8/23/20 and died at the hospital on 9/03/20. Record review revealed Resident #6's temperature had been taken 4 times in the month of August. Once on 8/19/20, twice on 8/21/20 and once on 8/23/20. On 8/21/20 at 7:49 PM he had a temperature of 102.1 and on 8/21/20 at 10:52 PM his temperature was 100.8.	F 880	for COVID 19 to ensure it□s being followed. This will be ongoing based on the CDC and local guidance for Covid-19 DON or designee would test residents and report the findings the resident or RP based on the current BIMs score and will document finding in the electronic health record. 4. 9/25/2020 Facility ran a Brief Interview for Mental Status (BIMS) report and highlighted all residents who scored an 8 or higher. These residents, with a score of 8 or higher would receive their test results via conversation and it would be documented in the electronic health record. Those residents BIMs below 8, their representative would receive the test results. Information will be audited on the Covid-19 result audit form each week for 12 weeks. 5. The DON/designee will present the results of the observations. 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.	

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 09/09/2020

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 880	Continued From page 20	F 880		

Record review revealed Resident #6's oxygen saturation had been taken once in the month of August on 8/23/20 at 6:26 PM and was 87% at that time.

Record review of progress notes and assessment records reveal no documentation of a respiratory assessment in August.

An interview with the Medical Director on 9/04/20 at 3:39 PM revealed he was unaware residents were not being assessed and monitored at least daily. He stated there were protocols in place to monitor all facility residents. He stated all COVID positive residents should have temperature, oxygen saturation, and lung assessment at least every 3-4 hours. He further stated he or the on-call physician should be notified for any abnormal vital signs or respiratory assessments. He stated it was not appropriate for the facility not to monitor COVID positive resident at least every 3-4 hours.

An interview with the Director of Nursing (DON) on 9/04/20 at 4:13 PM revealed she was unaware residents' temperature, oxygen saturation, and lung assessments were not being done daily on all non-COVID residents and three times per day on COVID positive residents.

An interview with the Interim Administrator and Regional Director of Operations on 9/08/20 at 11:45 AM revealed they were unaware vital signs including temperature, oxygen saturation and respiratory assessments were not being done every 4 hours for COVID positive residents and every shift for non COVID positive residents. They did not know why this was not being done.

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 09/09/2020

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 880	Continued From page 21	F 880		

2. CDC guidelines titled Preparing for COVID-19 in Nursing Homes updated 6/25/20 read in part "Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry."

Observations on arrival to the facility on 9/02/20 at 9:00 AM revealed the unlocked facility main entrance had no signage posted at entrance related to entrance check-in, infection prevention contact precautions, wearing Personal Protective Equipment (PPE), or visitor restrictions.

Observations on arrival to the facility on 9/03/20 at 9:15 AM revealed the unlocked facility main entrance had no signage posted related to entrance check-in, contact precautions, wearing PPE, or visitor restrictions.

CDC guidelines titled Responding to the Coronavirus (COVID-19) in Nursing Homes updated 4/30/20 read in part "Place signage at the entrance to the COVID-19 care unit that instructs HCP (Health Care Personnel) they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms."

Observations on 9/02/20 at 3:15 PM and 9/03/20 at 12:59 PM of the entrance of the designated COVID-19 area revealed no signage posted related to COVID-19, infection prevention contact precautions, visitors, or PPE. Observations inside the COVID-19 unit on 9/02/20 at 3:18 PM and 9/03/20 at 1:00 PM on the second set of entry doors revealed no signage posted related to

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 09/09/2020

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 880	Continued From page 22	F 880		

infection prevention contact precautions, PPE, or COVID-19 except for a diagram of how to put on and take off PPE which was taped to an interior window by the PPE storage. Observations inside the COVID-19 unit on 9/02/20 at 3:30 PM revealed no signage posted related to PPE or infection prevention contact precautions was posted on the resident's room doors.

An interview and observation with the Director of Nursing (DON) on 9/03/20 at 12:45 PM revealed the facility main entrance door was unlocked, had no PPE sign or visitor restriction sign. The COVID-19 entrance door had no signs of any type, the second set of entry doors in the COVID-19 area had no signs of any type. The DON stated she was unaware there were no signs posted on the facility entrance or COVID-19 area related to PPE and infection prevention precautions. She stated there should be infection prevention and PPE signage at all entry points.

An interview with the Interim Administrator and Regional Director of Operations on 9/08/20 at 11:45 AM revealed they believed there were PPE and visitor restrictions signs were in place on the facility main entrance door. They were unaware if the COVID-19 area had any contact precaution or PPE signs. They did not know why this was not done.

3. During the screening process to enter the facility on 9/02/20 at 9:00 AM, two of the two state surveyors were not required to perform hand hygiene. Observation on 9/02/20 at 9:00 AM of the entrance screening process for two employees revealed no hand hygiene was encouraged or verified.

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 09/09/2020

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 880	Continued From page 23	F 880		

During the screening process to enter the facility on 9/02/20 at 9:00 AM and on 9/03/20 at 9:15 AM, two of the two state surveyors completed the screening questionnaire. Staff were not observed to review the completed questionnaire.

Observations during this investigation revealed a hand sanitizer dispenser at the facility entrance.

An interview with Nurse #1 on 9/03/20 at 10:35 AM revealed she took her own temperature and answered the questionnaire on entrance to the facility. She also revealed she had not seen anyone review her temperature or completed questionnaire.

An interview with Nurse #2 on 9/03/20 at 10:59 AM revealed she had never seen anyone review the entrance questionnaire answers and she was unaware if they were reviewed.

An interview with the Director of Nursing (DON) on 9/04/20 at 4:13 PM revealed she was unaware the facility had not required hand hygiene to be performed. She stated she expected all visitors and staff to be screened and perform hand hygiene prior to entering resident care areas. She further stated she reviewed the entrance questionnaire form to ensure it was completed and did not evaluate the answers to ensure staff had no signs or symptoms of COVID-19.

An interview with the Interim Administrator and Regional Director of Operations on 9/08/20 at 11:45 AM revealed they were unaware hand hygiene was not required on entrance to the facility or if the completed questionnaire was reviewed. They did not know why this was not being done.

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 09/09/2020

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 880	Continued From page 24	F 880		

4. CDC guidelines titled Preparing for COVID-19 in Nursing Homes updated 6/25/20 read in part "Cancel communal dining and group activities, such as internal and external activities."

The facility's COVID Response Plan updated 9/02/20 read in part "No communal dining and no group activities outside of resident rooms except out of doors with 6' minimum distance between residents and required masks."

An interview with the Activities Director on 9/02/20 at 2:44 PM revealed the Resident Council meeting had been held in the West Annex dining room for July and August. She stated she asked the Administrator for and was given permission to gather residents for the meeting. She stated 10 residents attended the July 1, 2020 meeting and 7 residents attended the August 5, 2020 meeting. She stated they had placed the residents 6 feet apart during the meeting. The Activities Director also stated that due to the current COVID-19 outbreak, the September Resident Council meeting will be done individually by going to resident rooms.

An interview with the Director of Nursing (DON) on 9/04/20 at 4:13 PM revealed she was not the DON when the facility held a group Resident Council meeting and was not aware this had occurred. She also revealed the facility should not have group activities due to the COVID-19 pandemic.

An interview with the Interim Administrator and Regional Director of Operations on 9/08/20 at 11:45 AM revealed they were unaware the facility had held group activities in July and August. They

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 09/09/2020

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 880	Continued From page 25	F 880		

did not know why this was done.

5. Per CDC guidelines title Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20, read in part "Promptly (within 12 hours) notify HCP (Health Care Personnel), residents and families about identification of COVID-19 in the facility." It also read in part "Maintain ongoing, frequent communication with residents, families and HCP with updates on the situation and facility actions."

Record review of Resident #9's most recent Minimum Data Set (MDS) dated 8/01/20 indicated he was cognitively intact.

Record review of Resident #9's resident profile indicated he was his own responsible party.

An interview with Resident #9 on 9/02/20 at 12:45 PM revealed he had been tested for COVID-19 and stated he had not been informed of the results.

Record review of Resident #10's most recent MDS dated 7/09/20 indicated he was cognitively intact.

Record review of Resident #10's resident profile indicated he was his own responsible party.

An interview with Resident #10 on 9/02/20 at 10:56 AM revealed he had been tested 4 times for COVID-19 and had not been informed of the results.

An interview with the Director of Nursing (DON) on 9/04/20 at 4:13 PM revealed she performed the COVID-19 testing on the residents. She

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 09/09/2020

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 880	Continued From page 26 stated, "I told the residents she only tested residents who were not positive". An interview with the Interim Administrator and Regional Director of Operations on 9/08/20 at 11:45 AM revealed they were unaware if the residents had been informed of their test results.	F 880		