

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/11/2021
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345010 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/04/2021 |
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| NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ASHEVILLE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804 | | |
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| E 000 | Initial Comments An unannounced onsite COVID-19 Focused Survey was conducted on 12/29/2020. Additional information was obtained through 1/4/2021. Therefore, the exit date was changed to 1/4/2021. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# J65711. | E 000 | | | |
| F 000 | INITIAL COMMENTS An unannounced onsite COVID-19 Focused Survey was conducted on 12/29/2020. Additional information was obtained through 1/4/2021. Therefore, the exit date was changed to 1/4/2021. 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. Event ID# J65711. | F 000 | | | |
| F 880 SS=E | Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 880 | | 1/28/21 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 880 | <p>Continued From page 1</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents</p> | F 880 | | | |

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| F 880 | <p>Continued From page 2 identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 staff interviews, record review, review of the facility's COVID Response Plan and guidance from Centers for Medicare and Medicaid Services (CMS) dated 8/26/2020, the facility failed to implement the Coronavirus (COVID-19) screening process when 2 of 2 employees did not complete the required screening for the COVID 19 virus when they entered the facility (Nurse #1 and Nurse Aide #2). This failure occurred during a COVID pandemic.</p> <p>Findings included: A review of CMS guidance dated 8/26/20 states that regardless of the frequency of testing being performed or the facility's COVID-19 status, the facility should continue to screen all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19.</p> <p>A review of Accordius COVID Response Plan for North Carolina dated December 2020 on page 2 stated, "100% of staff entering/exiting center are screened with questionnaire and temperature check by a competent staff member."</p> | F 880 | <p>F880</p> <p>All residents are at risk from the failure to adhere with correct and adequate infection control processes as guided by the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS). CMS guidance states that all employees must be screened prior to beginning work. Facility had in place a screening process for employees to follow prior to beginning their shift for 12/28/20. Nurse # 1 and NA #2 failed to complete Their screening tools as she has been instructed. Facility also failed to review screening logs to ensure they were being completed. The Director of Nursing (DON) failed to follow facility policy for not allowing employees with reported signs and symptoms to work. On 1/04/21, the Regional Director of Operations for Accordius in-serviced the Administrator, Director of Nursing and Infection Control Preventionist on the facility policy and procedure for screening employees both before and after their</p> | | |

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| F 880 | <p>Continued From page 3</p> <p>A review of the daily staff assignment sheets dated 12/28/2020 revealed Nurse #1 worked 7:00 AM to 11:00 PM and Nurse Aide (NA #2) worked 11:00 PM to 7:00 AM.</p> <p>A review of the daily screening logs for 12/28/2020 revealed there was no information entered for Nurse #1 or NA #2.</p> <p>During an interview on 12/30/2020 at 10:00 AM Nurse #1 stated that she failed to complete the screening upon entry to the building the morning of 12/28/2020 because the sign in book was not at the front door when she arrived for her shift on 12/28/2020 and that she was unable to find the sign-in book that morning. She indicated she had come back to the front several times that morning to sign in and the book was not at the front. She explained she frequently had to search both nurse stations to find the sign-in book on the mornings of her shift requiring her to walk through the facility to find the sign-in book before she could screen herself. Nurse #1 indicated she was aware she was supposed to do the screening every time she entered and exited the facility. She explained she had been educated on the process of coming into the facility with a mask on, performing hand hygiene, having temp taken by another staff member, and completing the screening questions. She revealed staff did not consistently monitor the front door during the day, and that the sign-in process was usually "self-monitoring" on the honor system.</p> <p>During an interview on 12/30/2020 at 3:00 PM NA #2 stated he forgot to do the screening on 12/28/2020 when he arrived for his shift. He explained he had been educated on the process</p> | F 880 | <p>work shift. The Director of Nursing, Administrator and Infection Control Preventionist have also been instructed on how to handle staff reports of signs and symptoms prior to scheduled shifts to also include not reporting to work until medically cleared as per facility policy. This included but was not limited to the symptoms to look for and the temperature threshold regarding the employee responses on the log. Administrator or Director of Nursing will review all screening logs daily Monday- Friday to ensure all information is filled in correctly and fully. Personal Care Assistant will check logs on night shift. Personal Care Assistant will review logs for completion on Saturday and Sunday and will notify Director of Nursing or Administrator of any issues. Regional Director of Operations verified complete understanding of re-education upon completion with Director of Nursing, Administrator and Infection Control Preventionist to ensure proper delivery to all staff. All staff whether contract staff or contract employees, have been in-serviced by the Administrator and/or Director of Nursing on the facility screening process prior to the start of their shift. The remainder of staff will be in-serviced on this plan by telephone and review the plan in person when they arrive for their next assigned shift by the Administrator, Director of Nursing and/or Infection Control Preventionist. No person will be permitted to work on the floor until completing the in-service regarding this plan.</p> | | |

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| F 880 | <p>Continued From page 4</p> <p>of coming into the facility with a mask on, performing hand hygiene, having temp taken by another staff member, and completing the screening questions. He revealed that the sign in book was not at the front door for night shift and that it was kept at one of the nurse stations. He explained he would walk through the building to the nurse stations before completing the screening or taking his temp. Regarding 12/28/2020 sign in, he stated, "I'm sorry, I just forgot."</p> <p>During an interview on 12/29/20 at 3:45PM the Director of Nurses (DON) referred to the Accordius COVID Response Plan which states on page 2 under Actions To Be Taken: "100% staff entering/exiting center are screened with questionnaire and temperature check by a competent staff member." She further indicated that employees are to enter the building wearing a facemask, use provided hand sanitizer, have temperature taken by a competent staff member, record it on the log, answer the screening questions, and then clock in. She added that any employee with a temperature of 99.6 or greater was to call her directly during daytime hours and to call a night shift nurse if evening/night hours. The DON indicated the night shift nurses were responsible for the screening process on those shifts. The DON indicated she was the person responsible for collecting the sign in sheets each day and acknowledged she did not check the list daily to confirm each employee working that day had been screened. She indicated there was not a process for checking the sign-in book each day to determine if all employees had been screened.</p> <p>During a follow up interview on 12/30/20 at 3:30 PM the DON revealed that prior to 12/29/20, she</p> | F 880 | <p>Facility will assign Personal Care Assistant to the screening area to monitor sign in log to ensure all screening questions are answered without any issues 24 hours day 7 days per week. Prior to working screening area receptionist have been in-serviced on 01/04/2021 by the Administrator, Director of Nursing on process for completing screening tool per facility policy to ensure all screening questions are answered and there are no employees to start their shift if yes is answered to any screening questions or any temperature higher than 99.6 degrees Fahrenheit. Employees who answer yes to any of the screening tools will have to report to the Director of Nursing or Administrator prior to being allowed to start their shift. If Administrator or Director of Nursing is not in the building employee will have to call the Director of Nursing or Administrator before they can start their shift. Any employee with a temperature greater than 99.6 degrees Fahrenheit or showing any signs or symptoms related to covid-19 will be sent home as per facility policy. Employee will only be allowed back to work after being cleared by a physician.</p> <p>Administrator, Director of Nursing/Medical Record on weekday and the Manager on Duty on weeked will audit screening logs daily seven days per week at the beginning of each shift ongoing to ensure all employees have been screened prior to starting their shift.</p> <p>Administrator/Director of Nursing or Medical Record on weekday and the</p> | | |

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| F 880 | Continued From page 5 thought the employees were completing the screening process and signing in each day as they were taught to do. She further revealed she was not aware staff were screening themselves. She acknowledged all staff should be signing in each day according to CMS guidelines and Accordius COVID Response Plan. | F 880 | Manager on Duty will report findings to Quality Assurance Performance Improvement committee for any needed improvements. QAPI Committee will review ongoing to ensure compliance during Covid 19 pandemic. Completion Date 1/28/2021 | | |
| F 886 SS=E | COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. | F 886 | | 1/28/21 | |

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| F 886 | <p>Continued From page 6</p> <p>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;</p> <p>§483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.</p> <p>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.</p> <p>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.</p> <p>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interview and interview with the Local Health Department (LDH) the facility failed to conduct required Coronavirus (COVID-19) testing per Centers for Disease Control and Prevention (CDC) guidelines on all staff and 63 of 63 residents upon the identification</p> | F 886 | <p>F886 All residents are at risk from the failure to adhere with correct and adequate infection control processes as guided by the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid</p> | | |

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| F 886 | <p>Continued From page 7</p> <p>of a positive COVID-19 test result for Nurse Aide #1. From 11/30/20 to 12/28/20 a total of 1 staff have tested positive for COVID-19. This failure occurred during a COVID-19 Pandemic.</p> <p>Findings included:</p> <p>A review of the Accordius (facility's parent company) COVID Response Plan for North Carolina dated December 2020 on page 8 under Testing read in part: "Outbreak which is defined as any new case within the facility, all residents and staff should be tested who were previously negative."</p> <p>A CDC update for "Testing Guidelines for Nursing Homes" dated 10/16/20 states: "A single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and Health Care Providers (HCP) who are infected with SARS-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission. After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state</p> | F 886 | <p>(CMS). CMS guidance states in part: Outbreak which is defined as any new case within the facility, all residents and staff should be tested who were previously negative. Facility failed to timely test all residents who were negative after Nurse Aide #1 tested positive on 12/11/2021.</p> <p>On 1/04/21, the Regional Director of Operations for Accordius in-serviced the Administrator, Director of Nursing and Infection Control Preventionist on the facility policy and procedure for testing procedures after having a positive test result. The Director of Nursing, Administrator and Infection Control Preventionist have also been instructed on how to handle testing after a positive case. Administrator or Director of Nursing will monitor tests results weekly ongoing.</p> <p>Administrator or Director of Nursing will review all test results after every required test upon receiving test results for any positive test results. Administrator or Director of Nursing will ensure that any additional testing is performed immediately following a positive result on all previous negative staff and negative residents. Administrator or Director of Nursing will continue to monitor after each test =ing date results on going during the pandemic.</p> <p>Administrator or Director of Nursing will report all test result findings quarterly to Quality Assurance Performance Improvement committee for any findings</p> | | |

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| F 886 | <p>Continued From page 8</p> <p>health department. Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.</p> <p>A review of the facility's COVID testing results revealed the weekly testing of all staff completed on 12/9/2020 resulted in one positive result. The facility was notified on 12/11/20 Nurse Aide #1 was positive for COVID-19.</p> <p>A review of facility's testing of 63 residents on 12/14/2020 revealed no positive COVID-19 results reported on 12/16/2020. Review of the next testing for 62 residents occurred on 12/21/2020 with no positive results reported on 12/23/2020. There have been no positive resident cases in the facility to date.</p> <p>Review of the next testing for staff occurred on 12/14/2020 with results posted on 12/16/20. The facility continued to test negative staff weekly and there were no newly identified COVID-19 positive staff cases from 12/14/20 through 12/28/2020.</p> <p>During a telephone interview on 12/31/2020 at 2:30 PM the LHD Nurse confirmed she was the facility's contact nurse. The LHD Nurse indicated the COVID positive case had been reported to the LHD on 12/11/2020 via an electronic feed used by the lab. The LHD did not recall having a conversation with the DON on 12/11/2020 related to testing requirements and indicated there had</p> | F 886 | <p>for any needed improvement to testing of Covid 19. QAPI committee will review quarterly ongoing during Covid 19 pandemic.</p> <p>Completion date: 1/28/2021</p> | | |

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| F 886 | <p>Continued From page 9</p> <p>not been any recommendations made to the facility by the LHD on when to test next.</p> <p>During a telephone interview on 12/31/2020 at 3:30 PM the Director of Nursing (DON) acknowledged the facility was aware of the new COVID positive staff case on Friday, 12/11/2020, and did not require staff testing until Monday, 12/14/2020. She indicated the facility used 2 separate labs for testing staff and residents and she had concerns that testing over the weekend would create issues for lab pick up. In addition, she explained that getting staff together, including the contracted physical and occupational therapists, would be difficult over the weekend. She explained the regular testing date for staff was typically on Monday's and this was the reason for waiting until Monday, December 14, 2020.</p> <p>The DON acknowledged that follow up testing from a new positive COVID test should be as immediate as possible and preferably the same day. The DON indicated she was aware of the Centers for Medicare and Medicaid (CMS) testing recommendations for COVID-19 testing based on county positivity rates.</p> | F 886 | | | |