STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

(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 000	INITIAL COMMENTS The survey team entered the facility on 01/21/21 to conduct a complaint investigation. The survey team was onsite 01/21/21 through 01/27/21. Additional information was obtained offsite on 01/28/21. Therefore, the exit date was 01/28/21. Event ID# XIOK11. 3 of the 19 complaint allegations were substantiated.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff and Medical Director interviews, and hospital and facility record reviews, the facility failed to accurately transcribe the correct dosage formulation of a medication as ordered by the physician for 1 of 2 residents (Resident #3) reviewed for the provision of care according to professional standards. The findings included: Resident #3 was admitted to the facility on 3/11/20 with re-entry from a hospital on 11/12/20. Her cumulative diagnoses included hypertension, Type 2 diabetes, cardiac arrhythmia, anemia, and a history of cerebral infarction (stroke). Resident #3 ' s care plan included the following areas of focus, in part: --The resident is on aspirin related to atrial fibrillation (a type of heart arrhythmia). She is at	F 658	F-658 Resident #3 was discharged from the facility and no correction of orders were performed. On 1/25/2021 an in-service was conducted by the Accordius Health Regional Director of Clinical Services with the Director of Nursing of Accordius Health at Clemmons on review of admission orders within 24-72 hours of admission. On 1/25/2021 an in-service was conducted by the Director of Nursing to Nurse # 1 on transcription of new admissions orders to include the formation of aspirin. On 1/27/2021 an in-service was initiated for all licensed nurses on admission	1/29/21

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

Electronically Signed | 02/10/2021

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F 658	Continued From page 1 risk for excessive bleeding and bruising (Date Initiated: 3/27/20). -- The resident has anemia (Date Initiated: 3/27/20; Revision on: 7/20/20). Resident #3 ' s hospital discharge medication list dated 11/12/20 included 325 milligrams (mg) Enteric Coated (EC) aspirin to be given as one tablet by mouth daily. Enteric coated aspirin is designed to pass through the stomach to the small intestine before fully dissolving. Review of Resident #3 ' s 11/12/20 admission orders to the facility revealed the medication order was input into the facility ' s electronic system as 325 mg aspirin (not EC) to be given as one tablet by mouth daily. A review of the resident ' s November 2020, December 2020, and January 2021 Medication Administration Records (MARs) indicated 325 mg aspirin (not the EC formulation) was administered to the resident up until the date of her discharge (1/14/21). The resident ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/18/20. The resident was reported to have intact cognitive skills for daily decision making. She was totally dependent on staff for all of her Activities of Daily Living (ADLs) with the exception of requiring supervision only for eating. An observation was conducted on 1/25/21 at 12:52 PM of the 300 Hall medication cart formerly used for Resident #3 ' s med storage. This observation revealed one stock bottle of 325 mg aspirin (regular formulation) and one stock bottle of 325 mg EC aspirin were both stored on the med cart and either one was available for	F 658	orders of the formation aspirin completed on 1/28/2021 by the Director of Nursing. No licensed nurses will be allowed to work until in service has been completed. All new hired licensed nurses will receive this education in orientation. The in service included supplemental contract staffing. A 100% audit was conducted on 1/25/2021 by the Director of Nursing on all admission orders from January 1,2021 □ January 25,2021 for the correct of formation of aspirin. All new admission orders will be reviewed daily times 5 days weekly by the Director of Nursing or designees□ times (X) 12weeks. All discrepancies will be immediately reported to the administrator for consideration of the continuation of the plan. The Director of Nursing will present the data collected from the admission medication audits to the QAPI intradisciplinary team monthly times 3 months. QAPI members consist of the Director of Nursing, Medical Director, Administrator, Minimum Data Set Nurse, Treatment Nurse, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Activity Director, Assistant Activity Director, Maintenance Director, Dietary Manager an Environmental Supervisor. Plan of correction will be reviewed for continuation or modification. The Director of Nursing is responsible for this plan of correction and the alleged	

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F 658	Continued From page 2	F 658		

administration, depending on the physician ' s orders.

An interview was conducted on 1/25/21 at 1:15 PM with the facility ' s Medical Director, who also served as Resident #3 ' s Medical Doctor (MD). Upon inquiry, concern was expressed regarding administration of the regular formulation (versus EC formulation) of aspirin since her re-admission to the facility on 11/12/20. When asked about the significance of Resident #3 receiving 325 mg regular aspirin (versus the EC formulation), the MD reported he felt the most important factor was for her to have received aspirin because this medication was selected as her anticoagulant due to her medical history. The MD stated he did not feel the resident had been harmed by receiving the regular aspirin instead of an EC formulation.

An interview was conducted on 1/25/21 at 4:55 PM with Nurse #1. Nurse #1 was identified as the admitting nurse for Resident #3 when she re-entered the facility from the hospital on 11/12/20. During the interview, the nurse reviewed Resident #3 ' s hospital discharge medication list and the order she had input into the computer for 325 mg aspirin. At that time, Nurse #1 was asked about the selection of regular versus EC aspirin. The nurse stated the EC formulation may have been one of the choices for aspirin in the facility ' s electronic system, but she was not sure. Nurse #1 stated the medication should have been put into the electronic system as 325 mg EC aspirin.

An interview was conducted on 1/26/21 at 10:00 AM with the facility ' s Administrator. During the interview, the concern regarding the transcription

date of compliance is 1/29/2021.

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F 658	Continued From page 3 of Resident #3 ' s admission medication order for 325 mg EC aspirin input into the computer as 325 mg aspirin (regular formulation) was discussed. When asked, the Administrator reported the order should have been correctly input into the computer and a double check for accuracy should have been completed.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff and Medical Director interviews, and hospital and facility record reviews, the facility failed to monitor a resident ' s blood pressure and heart rate as ordered by the physician for 1 of 1 resident (Resident #3) reviewed who received multiple antihypertensive (blood pressure) medications. The findings included: Resident #3 was admitted to the facility on 3/11/20 with re-entry from a hospital on 11/12/20. Her cumulative diagnoses included hypertension, Type 2 diabetes, cardiac arrhythmia, anemia, and a history of cerebral infarction (stroke). Resident #3 ' s care plan included the following	F 684	F-684 Resident #3 was discharged from the facility and no correction of orders were performed. On 1/25/2021 an in service was conducted by the Accordius Health Regional Director of Clinical Services to the Director of Nursing of Accordius Health at Clemmons on review of admission orders within 24-72 hours of admission. On 1/25/2021 an in service was also conducted by the Director of Nursing to Nurse # 1 on transcribing parameters to monitor blood pressure and heart rate	1/29/21

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F 684	Continued From page 4 area of focus, in part: -- The resident has altered cardiovascular status. She is on metoprolol succinate and losartan to manage her blood pressure (Date Initiated: 3/27/20; Revision on: 7/20/20). The planned interventions/tasks indicated Resident #3 ' s vital signs would be monitored in accordance with her Medical Doctor ' s (MD ' s) orders (Date Initiated: 3/27/20). The resident ' s 11/12/20 hospital discharge medication list from her most recent hospitalization included, in part: 100 milligrams (mg) losartan (an antihypertensive medication) to be given as one tablet by mouth daily; and 100 mg metoprolol succinate (an extended release formulation of an antihypertensive medication) to be given as 1 and ½ tablets by mouth daily. A review of the discharge medication list revealed there were check marks next to each of these medications and a handwritten notation next to the order for metoprolol succinate which read, "Hold if HR (heart rate) < (less than) 55 or SBP (systolic blood pressure) < 110." Review of Resident #3 ' s 11/12/20 admission orders to the facility and her November 2020 Medication Administration Record (MAR) revealed the medication orders for losartan and metoprolol succinate were input into the resident ' s electronic medical record (EMR). However, the monitoring of vital signs (heart rate and blood pressure parameters) ordered by the physician were not included in either the orders or the resident ' s MAR. The resident ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/18/20. The resident was reported to have	F 684	when ordered. A 100% audit was conducted on 1/25/2021 by the Director of Nursing on all admission orders from January 1,2021 □ January 25,2021 on documentation of parameters for heart rate and blood pressure when administering hypertensive medications as ordered. On 1/27/2021 an in-service was initiated for all licensed nurses on admission orders transcription of parameters to monitor heart rate and blood pressure when administering antihypertensive medication by the Director of Nursing . No licensed nurses will be allowed to work until the in service has been completed. All new hired licensed nurses will receive this education in orientation. The in service included supplemental contract staffing. All new admission orders will be reviewed daily times 5 days weekly by the Director of Nursing or designees□ times 12weeks. All discrepancies will be immediately reported to the administrator for consideration of the continuation or modification of the plan. The Director of Nursing will present the data collected from the admission medication audits to the QAPI intradisciplinary team monthly times 3 months. QAPI members consist of the Director of Nursing, Medical Director, Administrator, Minimum Data Set Nurse, Treatment Nurse, Business Office Manager, Assistant Business Office Manager, Admission Coordinator, Activity	

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F 684	Continued From page 5 intact cognitive skills for daily decision making. She was totally dependent on staff for all of her Activities of Daily Living (ADLs) with the exception of requiring supervision only for eating. No heart rate or blood pressure readings were documented on Resident #3 ' s November 2020 MAR or December 2020 MAR. Further review of Resident #3 ' s EMR revealed only two heart rate and two blood pressure readings were documented within the record of her vital signs. On 12/2/20 at 10:57 PM, the resident ' s heart rate was 92 beats per minute (bpm) and her blood pressure was 126/92. On 12/13/20 at 5:14 AM, her heart rate was 80 bpm and her blood pressure was 150/80. No heart rate or blood pressure readings were documented on Resident #3 ' s January 2021 MAR up to the date of her discharge on 1/14/21. An interview was conducted on 1/25/21 at 12:35 PM with Nurse #1. Nurse #1 was identified as the admitting nurse for Resident #3 when she re-entered the facility on 11/12/20 after returning from a hospital stay. During the interview, the nurse reported the hospital discharge summary was typically used as the basis for admitting orders. When a resident was re-admitted, she stated the resident ' s MD would be contacted to receive admitting orders and the orders from the hospital discharge med list would be reviewed, confirmed, or changed at that time. After the orders were verified by the MD, the admitting nurse would put them into the facility ' s electronic system, and the medication orders would automatically be sent on to the pharmacy. A follow-up interview was conducted on 1/25/21 at 4:55 PM with Nurse #1. At that time, the nurse	F 684	Director, Assistant Activity Director, Maintenance Director, Dietary Manager an Environmental Supervisor. Plan of correction will be reviewed for continuation or modification. The Director of Nursing is responsible for this plan of correction and the alleged date of compliance is 1/28/2021.	

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F 684	Continued From page 6	F 684		

further reviewed Resident #3 ' s hospital discharge medication list and orders she had input into the computer for metoprolol succinate on 11/12/20. When asked about the omission of heart rate and blood pressure as monitoring parameters, the nurse replied, "I don ' t know why I didn ' t put that in." Nurse #1 indicated the heart rate and blood pressure parameters should have been input into the computer under "Additional Directions."

An interview was conducted on 1/25/21 at 1:15 PM with the facility ' s Medical Director, who also served as Resident #3 ' s Medical Doctor (MD). Upon inquiry, the MD reported he generally asked staff to monitor a resident ' s heart rate and blood pressure when he approved orders for blood pressure medications (particularly antihypertensive meds categorized as a beta-blocker, such as metoprolol succinate). When asked what his thoughts were regarding the facility ' s failure to routinely monitor and/or document these vital signs, he stated, "There ' s an issue." He added, "vital signs need to be done." During a follow-up interview conducted on 1/25/21 at 2:40 PM, the MD was shown Resident #3 ' s hospital discharge medication list from 11/12/20. The MD reported the notation of heart rate and systolic blood pressure parameters handwritten on the med list were written by him because he happened to be in the facility when the resident was re-admitted from the hospital on 11/12/20. The MD reiterated the vital sign parameters should have been part of the medication order for metoprolol succinate to ensure the resident ' s heart rate and blood pressure were monitored.

An interview was conducted on 1/26/21 at 8:30

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F 684	Continued From page 7 AM with the facility ' s Administrator. During the interview, concern was discussed regarding the failure to monitor Resident #3 ' s vital signs (heart rate and blood pressure) in accordance with the MD orders for metoprolol succinate upon her re-admission to the facility on 11/12/20. When asked if any additional records or documentation of vital signs were available for review, the Administrator reported none had been found. At that time, the Administrator reported she understood the concern regarding the resident ' s blood pressure and heart rate not having been documented in accordance with the MD ' s order.	F 684		