STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING ______ B. WING ______	C 03/08/2023

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

(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 Infection Control Survey was conducted from 03/07/23 to 03/08/23. 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# C51N11.	E 000		
F 000	INITIAL COMMENTS An unannounced complaint investigation and COVID-19 Focused Infection Control Survey was conducted from 03/07/23 to 03/08/23. NC00197610,NC00196515,NC195093,NC00194946 and NC00194388. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event: C51N11. 4 of 23 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, and record review, the facility failed to ensure a dependent resident could access the	F 558	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	3/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/28/2023

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 558 Continued From page 1

call light to request staff assistance for 1 of 5 residents reviewed for accommodation of needs (Resident #3).

Findings included:

Resident #3 was admitted to the facility on 1/12/22. with diagnoses that included anxiety disorder. His annual Minimum Data Set (MDS) dated 1/6/23 indicated he was cognitively intact. He required total assistance by staff for bed mobility, hygiene, and bathing.

A Care Plan dated 1/17/23 focused on fall risk included a goal for Resident #3 to be free from falls for the review date. Interventions included keep call light within reach and encourage resident to use it for assistance.

An observation was made on 3/7/23 at 10:25 AM of Resident #3 lying in bed with his call light cord wrapped around the assist bar and the paddle call light (a flat button used for people with limited hand movement) hanging next to the bed. Resident #3 indicated he was not able to use the paddle call light in that location.

An observation was made on 3/7/23 at 3:20 PM of Resident #3 in his wheelchair next to the bed. His paddle call light was on his bed. Resident #3 indicated he could not use the call light in that position. He could not reach his hand to the bed or move his chair to the bed.

During an interview on 3/7/23 at 3:25 PM, Nurse Aide (NA) #1 indicated Resident #3 could use the paddle light if it was placed next to his hand. NA #1 observed Resident #3 and revealed the call light was not within reach. NA #1 indicated that he

F 558

practice:Resident #3 call light is currently within his reach. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents who use call lights have been identified as having the potential to be affected. On 3/8/23 the August Healthcare□s Vice President and Regional Vice President of Operations, the Nursing Home Administrator and the Director of Nursing conducted facility wide observational rounds to assure call lights were within resident reach. On 3/8/23 the Nursing Home Administrator and Director of Nursing conducted additional quality observations to validate function and placement of call lights without concerns noted.
The measures the facility will take to ensure the problem will be corrected and will not reoccur:
Beginning 3/21/23 the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Unit Managers provided education to all staff on validating placement of the call light within reach when in a resident room.
The Administrator, DON, ADON, Unit Manager, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, or Admissions Director will perform ten random validation audits five times a week for four weeks then ten observations monthly for two months.
During rounds if any call lights are noted

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F 558	Continued From page 2 had just started his shift and he had not checked on Resident #3 since he had been there. The nurse aide moved the call light to Resident #3's arm rest and Resident #3 demonstrated use. During an interview on 3/8/23 at 9:00 AM, Resident #3 indicated his call light was frequently out of reach and he called out to get staff assistance. During an interview on 3/8/23 at 1:15 PM, the Director of Nursing (DON) indicated that Resident #3 was able to tell staff where he wanted his call light. The DON indicated call lights should be within reach. During an interview on 3/8/23 at 1:40 PM, the Administrator revealed she visited frequently and had not observed Resident #3 with his call light out of reach. She indicated that staff should ensure the residents' call lights were within reach.	F 558	to be out of reach, the team member who conducts the observation will place the call light within reach and notify the Nursing Home Administrator. The Nu7rsing Home Administrator will provide one to one re-education to the respective team member. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Nursing Home Administrator or Director of Nursing will present the audits to the facility□s Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audit and make recommendations to assure compliance ongoing. Date of Compliance: 3/27/23	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to provide care in a safe manner during a bed bath	F 689	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid	3/28/23

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F 689 Continued From page 3

for a dependent resident (Resident #3) resulting in a head injury for 1 of 3 residents reviewed for accidents.

Findings included:

Resident #3 was admitted to the facility on 1/12/22 with diagnoses that included quadriplegia. His quarterly Minimum Data Set (MDS) dated 7/22/22 indicated he was cognitively intact. He required total assistance from staff for bed mobility, hygiene, and bathing. He required two-person assistance for bathing.

A Care Plan dated 8/2/22 focused on fall risk included a goal for Resident #3 to be free from falls for the review date. Interventions included keep call light within reach, anticipate the resident's needs, and follow fall protocol. Resident #3 ' s Care Guide indicated he required 1 person assistance for bathing and showering and turning and repositioning in bed.

A facility incident report dated 8/26/22 indicated that Nurse Aide (NA) #2 was providing a bed bath and Resident #3 was on his left side. Resident #3 began shaking and stiffened his body causing him to jerk forward and roll off the bed. Resident #3 hit the right side of his head and complained of head and neck pain. Emergency Medical Services (EMS) was called, and Resident #3 was taken to the Emergency Department (ED).

ED documentation dated 8/26/22 revealed Resident #3 was seen following a fall. Diagnoses included a laceration to the forehead and subarachnoid hemorrhage (head bleed). His blood thinner was discontinued, and a seizure medication was added. The laceration to his

F 689

requirements. Preparation and/or execution of this correction does not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.
F689 Free of Accidents Hazards/Supervision/Devices
CFR(s): 483.25 (d) (1) (2)
The following corrective action(s) have been put into place for all residents including those who have been affected by the alleged deficient practice.

1. Resident #3 is currently being turned and repositioned per the facility's policy for Turning and Positioning. Resident #3 medical record was reviewed, and both the care plan for bed mobility and Minimum Data Set (MDS) section G0110 A were updated to reflect that the resident requires two-person assistance for bed mobility.
2. Residents who require assistance with turning and positioning have been identified as having the potential to be affected. Those identified residents had their most recent MDS section G0110 A and bed mobility care plan reviewed to validate accuracy.
3. On 3/9/23 the Minimum Data Set Coordinators were educated by the Director of Nursing on coding of section G0110 A and care planning bed mobility. Beginning 3/9/23 certified nursing staff

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F 689	Continued From page 4 forehead was closed with skin glue. A nursing progress note dated 8/29/22 revealed Resident #3 was complaining of blurred vision and was sent to the ED. He returned 9/1/22. A Nurse Practitioner note dated 9/1/22 revealed Resident #3 had returned from the ED and a magnetic resonance imaging (MRI) indicated the head bleed had not worsened and the blurred vision was likely post-concussion syndrome. During an interview on 3/7/23 at 10:25 AM, Resident #3 revealed he had a fall while NA#2 was providing a bed bath. He indicated she rolled him to the side and did not pull him close enough to her and he rolled onto the floor. He did not state if he was shaking or jerking. He went to the ED and was diagnosed with a concussion and a cut to the forehead and was sent back to the facility. Resident #3 added on 3/8/23 at 9:00 AM that he returned to the ED on 8/29/22 due to blurred vision. He indicated he had a scan, and his bleed was stable. He was not admitted to the hospital. His nurse practitioner followed up for the blurred vision and he has an appointment with an optometrist. NA #2 could not be reached for interview. During an interview on 3/8/23 at 1:15 PM, the Director of Nursing (DON) indicated he did not work at the facility at the time of Resident #3's fall. He revealed staff should use the Care Guide to determine how much assistance residents needed for bed baths. Staff was provided ongoing education of falls and bed mobility. During an interview on 3/8/23 at 1:40 PM, the	F 689	and licensed nurses will be educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Unit Managers on the facility's policy for turning and positioning. After 3/27/23 no certified nursing staff or licensed nurses will be permitted to work without first being educated by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Unit Managers on the facility's policy for Turning and Positioning. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Unit Managers will perform observation audits of five residents being turned and repositioned at various times three times a week for four weeks then will perform ten observational audits of residents being turned and repositioned at various times monthly for three months to validate compliance with the facility's policy for Turning and Positioning. If any resident is observed not being turned and repositioned per the facility policy the Nurse Manager conducting the observation will immediately intervene. The staff member will be removed from patient care, be provided one to one re-education, and will have five subsequent observations to validate compliance with the facility's policy for Turning and Positioning. Corresponding validation audits will be performed on section G0110 A of the respective MDS and the bed mobility care plan of the residents who were observed for turning and repositioning. If any care plan was not followed or any discrepancies in	

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F 689	Continued From page 5 Administrator indicated she did not work at the facility at the time of Resident #3's fall. She revealed that falls were discussed in morning meetings. The interdisciplinary team looked for the root cause of the fall and discussed interventions. The administrator indicated that staff was provided ongoing fall education. During an interview on 3/8/23 at 1:45 PM, the Vice President revealed that fall education was provided to nursing staff monthly. Falls were discussed in Quality Assurance (QA) meetings monthly.	F 689	documentation is noted, immediate action will be taken including the staff member will be removed from patient care, be provided one to one re-education, and will have five subsequent observations to validate compliance with the facility's policy for Turning and Positioning and the MDS Coordinators will be provided re-education by the Regional Vice President of Clinical Services. 4. The Director of Nursing will present the audits to the facility's Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audit and make recommendations to assure compliance ongoing. Compliance Date: 3/27/23.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		3/28/23

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§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems

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F 867	Continued From page 7 level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance.	F 867		

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§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 8/19/22 recertification and complaint investigation survey. This was for a recited deficiency in the area of accidents (F689). This deficiency was cited again on the current complaint investigation survey. The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

Findings included:

This tag is cross referenced to:

F689: Based on observations, record review, and staff and resident interviews, the facility failed to provide care in a safe manner during a bed bath for a dependent resident (Resident #3) resulting in a head injury for 1 of 3 residents reviewed for

F 867

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC).

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents residing in the facility have the potential to be affected.

The measures the facility will take to

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F 867	Continued From page 9 accidents. During the recertification survey on 8/19/22, the facility was cited at F689 accidents and hazards for failing to implement fall inventions, failed to secure smoking materials, and failed to provide supervision for smoking. During an interview on 3/8/23 at 1:40 PM, the Administrator revealed falls were discussed at monthly QAA meetings. The facility provided ongoing training to staff regarding falls as part of the QAA improvement plan. During an interview on 3/8/23 at 1:45 PM, the Vice President revealed falls were an ongoing issue for QAA at the facility and the facility continued to work to prevent falls.	F 867	ensure the problem will be corrected and will not reoccur: On 3/21/23 the Regional Vice President of Operations provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 3/24/23, under the direction and supervision of the Regional Vice President of Operations and Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff Development and Social Service Director on the QAPI process and the need of maintaining Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). Address how the facility will identify other residents having the potential to be	

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F 867	Continued From page 10	F 867	affected by the same deficient practice: Residents residing in the facility have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 3/21/23 the Regional Vice President of Operations provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 3/24/23, under the direction and supervision of the Regional Vice President of Operations and Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff Development and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoriAddress how corrective action will be accomplished for those residents found to have been affected by the deficient practice: August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders	

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F 867	Continued From page 11	F 867	with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents residing in the facility have the potential to be affected. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 3/21/23 the Regional Vice President of Operations provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 3/24/23, under the direction and supervision of the Regional Vice President of Operations and Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff Development and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING ______ B. WING ______	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12	F 867	cited. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An Ad Hoc QAPI meeting was held on 3/24/2023 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, ADON, Unit Manager, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, Admissions Director, Regional Vice President of Clinical Services and Regional Vice President of Operations. The QAPI Committee will meet weekly for four weeks starting on 03/24/23, then monthly until substantial compliance is obtained, to monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits / reports. The Administrator is responsible for ensuring this plan of correction is implemented. Date of compliance: 3/27/23	