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 02/28/2018

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

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F 000	INITIAL COMMENTS The Statement of Deficiencies was amended on 4/4/18 to correct errors in the 2567.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		3/28/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/23/2018

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 584

Continued From page 1

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on resident interviews, staff interviews and observations the facility failed to (1) maintain the walls in resident's rooms for 3 of 11 rooms (rooms 210, 305), (2) maintain the floors in residents rooms for 1 of 11 rooms (room 331), (3) maintain a clean environment in residents rooms for 2 of 11 rooms (rooms 210 and 203) and the facility failed to (4) provide a closet door/curtain in residents rooms for 1 of 11 rooms (room 301).

Findings included:

1a: An observation of room 210 occurred on 2-26-18 at 7:53am at which time the wall behind the head of her bed was noted to have paint peeling off exposing the plaster.

Room 210 was observed on 2-27-18 at 9:45am which revealed that cob webs remained in the resident's bathroom and the wall behind the head of her bed continued to show the paint peeling off with the plaster exposed.

An interview with the supervisor for the maintenance department occurred on 2-28-18 at 11:38am and he stated he was unaware of the paint peeling off and the plaster being exposed in room 210. During the conversation he stated that staff filled out a maintenance request form when they saw issues that needed to be fixed and that

F 584

F584

How/Why did Deficient Practice Occur:
When beds are placed against the walls in resident rooms, staff must be careful to move the bed away from the wall as they lower and raise the bed or rearrange the space, Otherwise, damage to the wall can easily occur. This damage was present in several rooms. Floor tile had been allowed to degrade without repair or replacement in one room. One room had no door cover for the closet. One room had cob webs in the bathroom that did not get cleaned for several days and another room had cob webs, leaves and debris trapped between the window and the window screen. A well-developed environmental plan includes ongoing inspection, reporting, repair and preventive strategies. All rooms should be cleaned well every day. The facility failed to have such a plan resulting in multiple rooms with wall damage as well as other symptomatic damage and inadequate housekeeping to other areas.

Response to Individual/ Systemic Component:
Each room cited for damage to the wall,

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F 584	Continued From page 2 he had not received any forms requesting repair to any resident's walls. The Administer was interviewed on 2-28-18 at 5:05pm. She stated she expected all residents' rooms and the building kept clean and maintained appropriately. 1b: An observation of room 305 occurred on 2-28-18 at 10:21am which revealed that there was paint peeling off the wall exposing the plaster next to dresser and night stand and behind the head of the bed. An interview with the supervisor for the maintenance department occurred on 2-28-18 at 11:38am and he stated he was unaware of the paint peeling off and the plaster being exposed in room 305. He was noted to make a note in his book and stated he would have it fixed as soon as he could. The Administer was interviewed on 2-28-18 at 5:05pm. She stated she expected all residents' rooms and the building kept clean and maintained appropriately. 2: Room 331 was observed on 2-28-18 at 10:27am at which time the floor between the residents room and the bathroom was noted to be cracked with the molding strip not attached to the floor. The resident who lived in that room stated the floor had been in that condition since his admission on 1-30-18. The maintenance supervisor stated on 2-28-18 at 11:45am that he was not aware of the issue in room 331 and that he had not received a work request for that room. He stated he would have	F 584	rooms 210, 305, 331, 319 and 301, had repairs completed that included painting, installation of bead board panel and a chair rail on the wall against which beds are placed. This bead board protects the wall from repeating similar damage through use of a sturdier surface and providing a neat and clean appearance. All resident rooms were inspected and scheduled for the same improvement. Wall repairs were completed as follows: Room 210 on 3/21/18, Room 305 was completed on 3/5/18, Room 331 was completed on 3/5/18, Room 319 on 3/21/18, and Room 301 on 2/17/18. Room 331 had floor tile and strip were worn and cracked. That tile and strip were removed and replaced with a new tile and strip on 3/5/18. All rooms were inspected and have been scheduled for replacement of damaged tile or strips. Room 301 had no curtain covering the closet area. A curtain was added to the closet allowing contents to remain private and improve the homelike appearance on 2/27/18. All resident rooms were inspected to assure there was a curtain or door covering the closet area. Cob webs were removed from room 210's bathroom and the room was thoroughly cleaned on 3/1/18. All rooms were inspected for similar inadequate housekeeping and were cleaned. Cob webs that had collected between the window and the screen of room 203 were removed and leaves and other debris removed on 3/1/18. All screens on resident room windows were removed	

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F 584	Continued From page 3 the issue fixed today and picked up the metal molding. The Administer was interviewed on 2-28-18 at 5:05pm. She stated she expected all residents' rooms and the building kept clean and maintained appropriately. 3a: Room 210 was observed on 2-26-18 at 7:53am at which time cob webs were noted to be across the ceiling in her bathroom. The corporate nurse was interviewed on 2-27-18 at 8:15am who stated that the facility was having difficulty since they contracted out their housekeeping department. She went on to state that housekeeping did not think that cleaning cob webs was part of their job. Room 210 was observed again on 2-27-18 at 9:45am with the cob webs still present across the ceiling in the resident's bathroom. The supervisor for the house keeping department was interviewed on 2-28-18 at 11:38am. He stated that his staff was responsible for the cleaning of the resident's rooms which included cleaning any cob webs that may accumulate. The Administer was interviewed on 2-28-18 at 5:05pm. She stated she expected all residents' rooms and the building kept clean and maintained appropriately. 3b: Room 203 was observed on 2-25-18 at 12:28pm revealing the window next to his bed had cob webs, leaves and dirt between the window and the screen. The screen was also noted to be popped out at the upper left corner	F 584	and the sill areas cleaned with screens securely replaced on 3/2/18. Rooms 301 and 203 were completed on 2/27/18. Room 331 was completed on 3/5/18. Rooms 319 and 305 were completed on 3/21/18. On 3/8/18, the administrator and Corporate consultant met with the housekeeping contractor to discuss expectations about building sanitation, agreed to staffing adjustments with additional training and established a system of rounds and reporting. The current housekeeping supervisor was replaced with a more experienced manager. Monitoring to Assure Sustained Compliance with Corrective Action: A comprehensive strategy has been developed to focus observation of all resident and common spaces to prevent areas from becoming worn, damaged or dirty without notice. The process is now in place as follows: Beginning on 3/28/18 all resident rooms were put on a weekly rounds circuit assigned to department heads. These rounds focus on condition, cleanliness and homelike space and are submitted to the Administrator for review, prioritizing and scheduling with the maintenance and housekeeping departments. Beginning with 3/28/18 the maintenance team began conducting weekly rounds of common areas focusing on condition and need for repair, cleanliness and opportunities to create a more homelike	

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F 584 Continued From page 4

and side.

The corporate nurse was interviewed on 2-27-18 at 8:15am who stated that the facility was having difficulty since they contracted out their housekeeping department. She went on to state that housekeeping did not think that cleaning cob webs was part of their job.

Room 203 was observed again on 2-28-18 at 11:03am which revealed that the cob webs, leaves and dirt were still present and the screen remained popped out at the upper left corner and side.

An interview with the maintenance supervisor occurred on 2-28-18 at 11:40am who stated he was unaware of the screen being lose and that he would have it fixed by the end of the day.

The supervisor for the house keeping department was interviewed on 2-28-18 at 11:38am. He stated that his staff was responsible for the cleaning of the resident's rooms which included cleaning the windows to make sure they were free from debris and cob webs.

The Administer was interviewed on 2-28-18 at 5:05pm. She stated she expected all residents' rooms and the building kept clean and maintained appropriately.

4: Room 301 was observed on 2-25-18 at 12:03pm at which time it was noted that the resident did not have a door or curtain covering her closet. The resident in the room stated she had requested a door for her closet "a few days after I was admitted".

F 584

environment Findings are reviewed with the administrator and prioritized for remediation and/or improvement. In addition, common areas have been placed on a preventive maintenance schedule to assure ongoing upkeep and to quickly recognize the need for repairs. Beginning the week of 3/28/18, the Administrator will accompany the maintenance director and Housekeeping manager on facility wide monthly rounds to include resident rooms and common areas. These focus on cleanliness, recognizing the need for repairs or improvements and opportunities to create a more homelike atmosphere.
A computerized system called REQQERS has been established by 3/28/2018 on the kiosks located in the corridors and on 4/4/2018 staff was trained to enter needs for repair, replacement or improvement of spaces, equipment or furnishings. The system is reviewed daily with entered requests prioritized, scheduled, and marked complete when appropriate.

QAPI:
All rounds, repairs and improvements are recorded and will be presented to QAPI for monitoring for a period of 6 months beginning with the April meeting. At the end of 6 months, the process will be reviewed and the QAPI committee will determine whether to continue current processes or revise the process as needed.

Who is Responsible:
The Administrator is responsible for

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 02/28/2018

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F 584	Continued From page 5 Another observation was made to room 301 on 2-28-18 at 11:10am revealing that the resident did not have a door or curtain over her closet. The maintenance supervisor stated on 2-28-18 at 11:45am that someone had removed the door from the closet but that he did not know why. He stated he would either have a door or a curtain hung for the resident by the end of the day. The Administer was interviewed on 2-28-18 at 5:05pm. She stated she expected all residents' rooms and the building kept clean and maintained appropriately. She also stated she expected the residents to have a door or a curtain covering their closet unless the resident requested not to have one.	F 584	ongoing compliance with this corrective action which will be completely implemented by 3/28/18.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		3/28/18

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F 636	Continued From page 6 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 636 Continued From page 7

(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete an admission assessment for 1 of 1 residents (resident #8) upon her return from the hospital.

Findings included:

Resident #8 was admitted to the facility on 2-14-18 with multiple diagnoses that include peritonitis, pneumonia, c-diff, epilepsy and tracheotomy.

The Minimum Data Set (MDS) dated 12-12-17 revealed that the resident was cognitively impaired and needed total assistance with one person for bed mobility, dressing, eating and personal hygiene. Resident #8 was also coded for oxygen use, tracheotomy care, and suctioning and tube feedings.

Resident #8's care plan dated 1-9-18 revealed a goal for the resident not to have any signs or symptoms of infection. The interventions for this goal included ensuring tracheotomy ties are secure, provide good oral care, suction as necessary and use universal precautions. A second goal was created on 2-20-18 for resident #8 not to have any adversities from c-diff. The interventions for this goal included administering antibiotics as ordered and enteric precautions for c-diff.

A review of resident #8's nursing notes revealed that she requested to go to the hospital on 1-22-18 for right sided pain and that she was sent to Forsyth Hospital. During further review it was

F 636

How/Why did this Deficient Practice Occur:
A full assessment must be completed of each resident who is admitted or readmitted in accordance with standards established in 483.20. This assures those charged with planning care have complete information about the resident's medical history, current health and psychosocial status. Due to unfamiliar and inconsistently trained staff, these assessments were incomplete or not undertaken at all.
Response to Individual/Systemic Component:
-Resident #8 has had a full post admission assessment to assure a complete understanding of condition and appropriate planning for care. The MDS and Care Plan for Resident #8 have been updated to reflect accurate and up to date information. This was completed on 3/23/2018.
-Resident #278 has been fully assessed and skin integrity closely noted. He continues to be treated for wounds identified and is properly coded on the MDS and plan of care implemented. This was completed on 2/28/2018.
On 3/28/2018 nursing staff was in-serviced on the facility's admission protocol (see attached) which requires a complete assessment be completed on each admission and readmission within 24 hours of admission. The elements required are outlined on the Admission

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	345131	A. BUILDING ______ B. WING ______	C 02/28/2018

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F 636	Continued From page 8 noted that there was no nursing assessment completed prior to sending the resident to the hospital. The hospital discharge paperwork revealed that resident #8 was admitted on 1-22-18 with a collapsed right lung, right lower quadrant abdominal pain and pneumonia. While in the hospital the resident was diagnosed with acute appendicitis and colitis due to clostridium difficile (c-diff). The resident was discharged from Forsyth Hospital on 2-12-18 and returned to the facility. A review of the facility's medical record for resident #8 revealed that there was no readmission assessment completed on the resident when she returned from the hospital. An interview with the nurse (nurse #3) occurred on 2-27-18 at 8:05am. She revealed that when a resident was readmitted to the facility that the nurse on shift should complete an assessment of the resident "so they know what is going on with them". The facility's corporate nurse was interviewed on 2-28-18 at 9:30am in regards to readmission assessments and she revealed that there would be an assessment completed when a resident was readmitted to the facility from a hospital stay. During the course of the conversation, the corporate nurse stated that there was not an assessment completed on resident #8's readmission to the facility. An interview with the Administrator occurred on 2-28-18 at 5:05pm. The Administrator stated she expected the staff to complete a full assessment	F 636	Checklist (attached) which is reviewed and counter-signed by a second nurse assigned to validate the admission process has been completed. A full skin check is a required part of the admission and readmission process and is included on the checklist for validation. Monitoring to Assure Sustained Compliance with Corrective Action: The DON maintains a list of new admissions and readmissions and verifies she has received a completed checklist by the day after an admission/readmission. If no checklist is provided to the DON, she will seek out the data and the individuals who were assigned, to assure it has been completed or that it is completed immediately if not already done. As a final measure to assure all clinical and psychosocial care elements are addressed for the new admission or readmission, the new or newly readmitted residents' care elements are added to the Nursing Clipboard (see attached) for ongoing review by the interdisciplinary team. QAPI: The validation process is recorded on an audit tool which will be reviewed in QAPI on a monthly basis for 6 months with the team making recommendations about continued monitoring based on findings. The DON is responsible for compliance with this corrective action which is completed by 3/28/18.	

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F 636	Continued From page 9 on residents that are new admissions as well as residents that are being readmitted.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for 2 of 17 residents (#3 and #179) reviewed for pressure ulcers, falls and nutrition. Findings include: 1. Resident #3 was admitted to the facility on 10/20/17 with diagnoses to include encounter for other specified aftercare, chronic systolic congestive heart failure, and enterocolitis due to clostridium deficile A review of Resident #3's most recent MDS dated 12/9/17 was coded as a 30 day Medicare scheduled assessment. Resident #3's MDS coded the active diagnoses as hypertension, heart failure, diabetes mellitus, hyperlipidemia, depression, encounter for other specified aftercare, muscle weakness, enterocolitis d/t clostridium deficile, and encephalopathy. A review of the MDS section M: skin conditions revealed the assessment was coded as no pressure ulcer present. A review of Resident #3's medical record	F 641	F641 How/Why Deficient Practice Occurred: Accurate coding of the MDS requires careful attention to the detailed summaries provided by hospitals/physicians at the time a resident is admitted or/and readmitted as well as those new findings generated by thorough physical/psychosocial/nutritional/recreational assessments completed upon admission, readmission and periodically as required. An MDS nurse is expected to view and observe a resident prior to completing the MDS as well as thoroughly review the clinical record, and to verify and validate information prior to entering the data in the MDS. In addition, the MDS nurse should be accumulating new information from clinical updates, reports, and risk meetings which include key members of the nursing and interdisciplinary team. The MDS nurses who failed to accurately code the MDSs cited in this SOD failed to meet these minimum standards and will be re-educated and monitored to assure improved accuracy in future assessments.	3/28/18

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 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 641 Continued From page 10

revealed a wound assessment noted dated 12/7/1which noted an unstageable pressure ulcer to the left heel that was present on admission to the facility.

An interview was conducted with the MDS nurse and the corporate nurse consultant on 2/28/18 at 3:00pm. The MDS nurse reported she is responsible for coding the MDS assessments. The corporate nurse consultant reported it is her expectation that all MDS assessments are coded correctly.

An interview was conducted with the administrator on 2/28/18 at 5:30pm. She reported it is the responsibility of the MDS nurses to code all MDS assessments. The administrator reported it is her expectation that all MDS assessments are to be coded accurately.

2. Resident #179 was admitted to the facility on 10/11/17 and diagnoses included vascular dementia with behavioral disturbances, dysphagia, cerebral vascular accident (CVA) affecting right side, lack of coordination and abnormalities of mobility.

A review of the incident reports for Resident #179, provided by the Administrator, revealed the resident had fallen on 10/12/17, 10/18/17 and 11/11/17.

A review of the electronic medical record (EMR) for Resident #179 revealed his weights were: 124 lbs. on 2/2/18, 125 lbs. on 1/3/18 and 132 lbs. on 12/9/17. There was an entry with the 1/2/18 weight of 125 lbs. that stated - (negative) 5% change over 30 days (comparison weight 12/9/17, 132 lbs., -5.3%, -7 lbs.)

F 641

Response to Individual Component Immediately:
For Res #3, MDS nurse has modified and is now correctly coded for his loss of skin integrity on 3/9/2018.
Res#179, it was confirmed that the falls occurred prior to the last scheduled PPS assessment date of 12/12/17, so were not coded on the 1/9/18 as per the RAI manual instructions. The coding was correct with the RAI manual instructions. The record now correctly reflects the significant weight changes.

Response to Systemic Component:
To assure all information is current, 100% audit of weight and wound reports was initially completed 3/7/2018 by the Clinical Dietary Manager and then completed by the RD on 3/30/18 with MDS updates and corrections completed. In addition, the Nursing Clipboard was compared to the MDS coding to assure all current residents have correct coding reflected in their MDS. The team will review MDS documentation during clinical and risk meetings on an ongoing basis to assure documentation is accurate, current and complete.
MDS nurses were in-serviced on 3/22/18 regarding RAI expectations and methods of collecting data to accurately code reflecting residents' condition. Each has also completed an educational series on "SmartZone" a training series produced by Relias, that details RAI processes and requirements which was required to be completed by April 6, 2018. The MDS

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 02/28/2018

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 641

Continued From page 11

A quarterly minimum data set (MDS) dated 1/9/18 for Resident #179 identified the resident had not had any falls since admission to the facility, his weight was 125 pounds (lbs.) and had not experienced a significant weight loss.

The MDS nurse that had completed the 1/9/18 MDS for Resident #179 was not available for an interview.

An interview on 2/28/18 at 3:19 pm with the Regional Nurse revealed it was her expectation that residents MDS's are coded accurately and based on their health conditions during the assessment look back period. She acknowledged Resident #179 ' s MDS was coded incorrectly for falls and weight loss.

F 641

nurses attend morning clinical review daily X5 during which the Clinical Clipboard is updated which details resident conditions including falls, wounds, weights, antibiotic use, new psychoactive use, new opioid use and more. MDS attends the Risk meeting which is a weekly detailed review of the same and additional information. Each of these sessions includes team decisions about and documentation of, managing resident changes, care planning, documentation, significant changes and more. MDS is charged with updating care plans and MDS. The entire team is charged with strategizing interventions and progress notes. The Administrator sits in on both clinical review and Risk frequently and at random and will monitor to assure the process is fully implemented by both Nursing and MDS.

Monitoring to Assure Sustained Compliance with Corrective Action:
The Corporate MDS nurse will review 3 MDSs at random monthly comparing the coding to the clinical record to determine accuracy, comprehensiveness and correct coding. Results of these audits will be presented to the Administrator as they are completed for review then presented to the QAPI committee beginning with the April meeting and each month for 5 additional months. If accuracy is less than 100% all monitoring will continue.

Who is Responsible:
The Administrator is ultimately responsible for MDS management and will assure compliance by 3/28/18.

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 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		3/28/18

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 02/28/2018

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F 656	Continued From page 13 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop and implement a comprehensive care plan for 4 out of 10 residents (Residents #3, 275, 277, and 175) that were reviewed for accidents, unnecessary medications and contact precautions. Findings Included: 1. Resident #175 was admitted to the facility on 1/20/18 and diagnoses included chronic kidney disease, sepsis, diabetes, fibromyalgia, peripheral neuropathy, muscle weakness and difficulty walking. Review of a care plan dated 1/22/18 for Resident #175 identified a nursing baseline care plan stating resident needed assistance with ADL ' s and was at risk for pain, falls and skin issues. Resident was on contact isolation related to C-diff and resident had pain related to neuropathy and fibromyalgia. Review of the admission minimum data set (MDS) dated 1/27/18 for Resident #175 revealed the care area assessment ' s and care planning in Section V0200 stated the following areas would be addressed in a care plan: Activities of daily living (ADL ' s), Urinary Incontinence and Indwelling Foley Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer and Psychotropic Drug Use.	F 656	Care Planning is an essential process designed to assure that when properly implemented, a resident's care is focused on assisting the resident to meet his highest practicable level of function. Failure to accurately assess and plan for care places the resident at risk of not meeting that mandate. The Baseline Care Plan focuses care until the comprehensive assessment is completed on or about day 14 with Care Area Assessments completed noting that each triggered area is either included in the Care Plan or a justification presented for why it need not be included. A new MDS nurse failed to fully understand the complex process and requires additional training and monitoring to assure all elements are complete, accurate and timely. Resident #3 care plan has been corrected to include the use of contact isolation which was correctly noted as a diagnosis in the MDS. Resident #275 is now properly care planned for use of an anticoagulant as correctly coded in the MDS. Resident #277 now has depression included in her plan of care. The MDS nurse has been in-serviced on the elements of the RAI including correct coding, use of the CAAs and accurate, effective care planning on March 22,2018. SmartZone/ Relias RAI educational tools	

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 02/28/2018

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F 656 Continued From page 14

Review of the medical record for Resident #175 following the completion of the 1/27/18 MDS revealed there were no care plans established since the initial care plans dated 1/22/18.

An interview on 2/26/18 at 4:28 pm with the MDS nurse revealed she worked part-time and was being trained by the full-time MDS nurse who was on vacation this week. The MDS nurse stated she initially thought the baseline care plan that was created for resident ' s on admission would suffice for their care plan. She added since then she has learned that a resident ' s care plan should be based on how the care area assessment questions are answered. The MDS stated this had not been done for Resident #175 and she would have to go back and make corrections to the residents care plans.

An interview on 2/28/18 at 3:15 pm with the Regional Nurse revealed she expected the Resident Assessment Instrument rules to be followed. She added if the care area assessments decision was to proceed to care plan a care plan should be developed.

2.a. Resident #3 was admitted to the facility on 10/20/17 with diagnoses that include Encounter for Other Specified Aftercare, Dysphagia, Chronic Systolic Congestive Heart Failure, Enterocolitis due to Clostridium Difficile, and Diabetes Mellitus.

A review of Resident #3's medical record revealed a nursing note dated 12/8/17 at 6:30 am that reported resident continues on contact precautions due to clostridium difficile.

F 656

are now required to be completed within 14 days of signing up and annually thereafter.
The Corporate MDS nurse will randomly select 3 MDSs per month to review for accurate completion and correct care planning strategies. Data from these random audits will be included in monthly QAPI meetings for 6 months then evaluated to determine the need to continue based on findings.
The Administrator is responsible for assuring ongoing sustained compliance with this corrective action which will be fully implemented by March 28, 2018.

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 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 656 Continued From page 15 F 656

Resident #3's most recent MDS (Minimum Data Set) dated 12/9/17 was coded as a 30-day Medicare assessment. The MDS coded the active diagnoses as Heart Failure, Hypertension, Diabetes Mellitus, Hyperlipidemia, Encounter for other specified aftercare, Dysphagia, and Enterocolitis d/t clostridium difficile.

A review of Resident #3's care plan dated 12/18/17 did not address isolation contact precautions.
b. Resident #275 was admitted to the facility on 2/1/18 with diagnoses that include Hypertension, Diabetes Mellitus, Hyperlipidemia, Depression, Respiratory Failure, and Encounter for Other Specified Aftercare.

A review of Resident #275's medical record revealed a physician's order dated 2/2/18 that read Eliquis 2.5mg give 1 tablet twice a day for anticoagulant.

A review of Resident #275's most recent MDS dated 2/8/18 and coded as an admission assessment revealed the resident had active diagnoses of Encounter for Other Specified Aftercare, Hypertension, Diabetes Mellitus, Depression, and Respiratory Failure. A review of the MDS revealed Resident #275 was cognitively impaired. The MDS under Section N: Medications revealed the resident had received an anticoagulant 7 out of 7 days of the assessment period.

The Care Plan for Resident #275 dated 2/14/18 was reviewed and did not address anticoagulant therapy.

c. Resident #277 was admitted to the facility on

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 02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 16 2/5/18 with diagnoses that included Encounter for Other Specified Aftercare, Panlobular Emphysema, Orthostatic Hypotension, Major Depressive Disorder, and Peripheral Vascular Disease Unspecified. A review of Resident #277's medical record revealed a physician's order dated 2/5/18 for Sertraline 25mg one time a day. Resident #277's most recent MDS dated 2/19/18 was coded as a 14-day assessment. The MDS revealed active diagnoses of Anemia, Orthostatic hypotension, PVD, Depression, Asthma, Chronic Kidney Disease, and Aspiration Pneumonitis due to aspirated food. Resident #277's MDS revealed the resident received an antidepressant 7 out of 7 days during the assessment period. A review of Resident #277's care plan dated 2/19/18 does not address depression. An interview was conducted with the MDS nurse and the corporate nurse consultant on 2/28/18 at 3:00pm. The MDS nurse reported she is responsible for developing and revising care plans. The corporate nurse consultant reported it is her expectation that all care plans should be individualized and address all care areas. An interview was conducted with the administrator on 2/28/18 at 5:30pm. She reported it is the responsibility of the MDS nurses to develop and revise all care plans. The administrator reported it is her expectation that all care plans should include all care areas and each care plan be individualized to each resident.	F 656		
F 657	Care Plan Timing and Revision	F 657		3/28/18

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 02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657 SS=D	Continued From page 17 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 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 update the care plan for 3 of 3 residents that had experienced significant weight loss (Resident #50, Resident #179 and Resident #43.) Findings Included:	F 657	F657 Why/How Deficient Practice Occurred: Due to a turnover in staff those assigned to admission, readmission, weekly and monthly weights, did not complete those weights reliably and consistently. This caused the three cited residents to have unrecognized weight loss although most	

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	345131	A. BUILDING ______ B. WING ______	C 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 657 Continued From page 18

1. Resident #50 was admitted to the facility on 12/19/17 and diagnoses included bipolar disorder and Alzheimer ' s disease. The resident was hospitalized 1/18/18 through 1/23/18 and 2/1/18 through 2/8/18 with additional diagnoses of acute cholecystitis w/ chronic cholecystitis and calculus of the bile duct.

A care plan for Resident #50 dated 1/16/18 stated the resident was ordered a regular diet. The resident will continue to enjoy her prescribed diet without any nutritional complications through the next review date. Interventions included to allow and encourage family / friends to provide additional food and snacks if resident desired, assist with meals as needed, observe for any chewing / swallowing issues, provide alternate meal if requested, refer to the Registered Dietitian (RD) as needed for nutritional consultation and resident prefers to eat meals in her room.

Review of the electronic medical record (EMR) for Resident #50 identified her most recent weight was 115 lbs. on 1/3/18.

An interview on 2/28/18 at 12:00 pm with the Regional Nurse (RN) revealed she had located an additional weight in the weight book for Resident #50. The weight was obtained on 1/24/18 as 98 lbs. She added the resident had not been weighed again when she was re-admitted to the facility on 2/8/18 and they were obtaining a weight today.

During an interview on 2/28/18 at 1:15 pm with the RN she stated they had obtained Resident #50 ' s weight today and she weighed 89 lbs. The RN acknowledged that the resident had experienced a 26 lb. / 22% weight loss from

F 657

residents were weighed. This system breakdown has been resolved and is now operating reliably and consistently. The residents cited have had interventions put in place and their MDS and Care Plans corrected.
Response to Individual Component:
Resident #50 has experienced a significant weight loss which is now correctly Care Planned. Note: this resident has been readmitted from a recent hospitalization and is now on palliative care.
Resident #179 has experienced a significant weight loss which is now correctly coded in their MDS.
Resident #43 experienced a significant weight loss which is now correctly coded in their MDS.
These changes were completed 3/6/2018.
Response to Systemic Component:
A 100% audit of all resident weights was initially completed by the Dietary Manager on 3/7/2018 and by the RD on 3/30/2018 with interventions initiated as appropriate and MDS/Care Plans updated to reflect changes and interventions.
In response to this identified deficiency, a new system has been established to assure the clinical team is aware of weight changes, able to respond promptly and the MDS team is able to correctly code and care plan those changes.
The Restorative Aid was in-serviced on 3/17/18 about the correct method of collecting weights including the use of the same scale, at near the same time with near the same attire. Each factor is noted in the weight log.

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 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 657

Continued From page 19

1/2/18 to 2/28/18. She added the care plan for Resident #50 should be updated to reflect her current weight status.

2. Resident #179 was admitted to the facility on 10/11/17 and diagnoses included vascular dementia with behavioral disturbances, dysphagia and cerebral vascular accident (CVA) affecting right side.

A care plan dated 1/30/18 for Resident #179 stated resident was ordered a mechanically altered diet. The resident will continue to enjoy his prescribed diet without any nutritional complications through the next review. Interventions included to assist with meals as needed, observe for any chewing / swallowing issues, provide alternate meal if requested and refer to the Registered Dietitian (RD) as needed for nutritional consultation.

A review of the electronic medical record (EMR) for Resident #179 revealed his weights were: 124 lbs. on 2/2/18, 125 lbs. on 1/3/18 and 132 lbs. on 12/9/17. There was an entry with the 1/2/18 weight of 125 lbs. that stated - (negative) 5% change over 30 days (comparison weight 12/9/17, 132 lbs., -5.3%, -7 lbs.)

An interview on 2/28/18 at 11:50 am with the Director of Nursing (DON) revealed residents with weight loss were discussed in the daily clinical meeting. She stated new interventions for weight loss should be added and their care plans should be updated. The DON added she could not recall discussing weight loss for Resident #179.

3. Resident #43 was admitted to the facility on 7/14/17 and diagnoses included schizophrenia,

F 657

Weekly weights are now completed and recorded by the end of the day on Tuesday in preparation for clinical review and Risk which occurs on Wednesday. All new admissions and readmissions are weighed within 24 hours of admission/readmission and presented to the DON for review. Monthly weights are completed by the 5th of the month and recorded by the 7th. All weights are reviewed by the DON in preparation for the Risk meeting in order to identify residents who are at risk of weight loss or are actually incurring weight changes. During Risk on Wednesdays and during clinical review Monday through Friday, weight changes are reviewed, interventions implemented and care plans updated. The Certified Dietary Manager reviews weights at admission, readmission for care planning and weekly and monthly for ongoing management. The Registered Dietician reviews new admissions, readmissions and those residents with identified risk of loss or gain. Each clinician has the ability to seek interventions so the team can respond quickly to changes that create risk.
MDS has been in-serviced on 3/28/18 to review weights, as well as other clinical factors, prior to completing an assessment to assure proper coding and care plan interventions appropriately. The Clinical Team, led by the DON, will review MDSs of residents at risk to confirm the weight change or risk of weight change has been captured and addressed by the MDS and Care Plan team.
Monitoring to Assure Sustained Corrective

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 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 657	Continued From page 20 diabetes, chronic obstructive pulmonary disease and gastroesophageal reflux disease. A care plan for Resident #43 dated 2/20/18 stated the resident was currently on a regular diet. She was edentulous and wore upper and lower dentures. Risk for mouth pain. The resident will continue to enjoy her prescribed diet without any nutritional complications through the next review. Interventions included to allow and encourage family / friends to provide additional food and snacks if resident desired, assist with meals as needed, observe for any chewing / swallowing issues, provide alternate meal if requested and refer to the Registered Dietitian (RD) as needed for nutritional consult. Review of the medical record for Resident #43 revealed her weights were: 2/26/18 - 172 pounds (lbs.), 2/19/18 - 169 lbs., 2/2/18 - 185 lbs., 1/16/18 - 207 lbs. This reflected an 18% weight loss from 1/16/18 to 2/19/18. A phone interview with the RD on 2/28/18 at 9:15 am revealed the MDS nurses were updating the care plans for nutrition and weight loss, but she was going to start working on these areas now that she was coming to the facility weekly. An interview on 2/28/18 at 11:50 am with the Director of Nursing (DON) revealed residents with weight loss were discussed in the daily clinical meeting. She stated new interventions for weight loss should be added and their care plans should be updated.	F 657	Action: The Corporate MDS nurse will review 3 MDSs at random on a monthly basis. Data from this review will be presented to the Administrator who as oversight of the MDS Coordinator then presented to the QAPI committee for review beginning with the April meeting and continuing for 5 additional months. If compliance is not found to be 100%, the audits will continue until compliance is 100% for three consecutive months. Who is Responsible: The administrator is ultimately responsible for this corrective action which will be full compliant by 3/28/18.	
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		3/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	**3905 CLEMMONS ROAD CLEMMONS, NC 27012**

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F 692	Continued From page 21 §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, observations and staff interviews the facility failed to identify and assess a resident with significant weight loss (Resident #50) and failed to provide interventions for a resident with identified significant weight loss (Resident #179.) This was evident in 2 of 5 residents reviewed for nutrition. Findings Included: 1. Resident #50 was admitted to the facility on 12/19/17 and diagnoses included bipolar disorder and Alzheimer ' s disease. The resident was hospitalized 1/18/18 through 1/23/18 and 2/1/18 through 2/8/18 with additional diagnoses of acute cholecystitis w/ chronic cholecystitis and calculus	F 692	This citation is a combination of concerns about the timing and manner of collecting and reporting residents weights as well as noting correctly and timely interventions to prevent or halt weight loss. Weights were not collected on a dependable schedule and kept readily available to the RD for review and action. Resident #50 is noted to have experienced significant weight loss which has now been addressed with accurate weighing strategies reported to the IDT and the RD on a timely basis and improved meal service. This resident continues on a plan of weekly weights with ongoing and progressive	

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 02/28/2018

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ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 692

Continued From page 22

of the bile duct.

A care plan for Resident #50 dated 1/16/18 stated the resident was ordered a regular diet. The resident will continue to enjoy her prescribed diet without any nutritional complications through the next review date. Interventions included to allow and encourage family / friends to provide additional food and snacks if resident desired, assist with meals as needed, observe for any chewing / swallowing issues, provide alternate meal if requested, refer to the Registered Dietitian (RD) as needed for nutritional consultation and resident prefers to eat meals in her room.

A comprehensive minimum data set (MDS) dated 1/30/18 for Resident #50 identified her weight was 115 pounds (lbs.), had not experienced any significant weight changes, required supervision with eating and had impaired cognition.

An observation of Resident #50 on 2/25/18 at 5:13 pm revealed resident was lying in bed and appeared very thin. The resident did not respond to any questions. Resident #50 ' s roommate stated she had not been eating since she returned from the hospital.

Review of the electronic medical record (EMR) for Resident #50 identified her most recent weight was 115 lbs. on 1/3/18.

Review of the February 2018 physician orders for Resident #50 identified she was on a regular diet. There were no supplements ordered.

Review of a nutrition note completed by the RD, dated 2/9/18 stated the resident was seen for re-admission nutrition assessment. Resident

F 692

interventions intent to stabilize this resident□s weight.
Resident #179 is pleased to be served bread with each meal along with double portions per order. In addition, resident #179 is receiving the correct quantities of food as the dietary staff now understands correct portioning.
The process for collecting and reporting weights has been revised for the facility and the IDT, Dietician, Nurses and Restorative aides in-serviced on the new process. The Restorative Aides are responsible for collecting weight from residents within 24 hours of admission or readmission, weekly for 4 weeks after admission or readmission and monthly thereafter unless otherwise ordered. A new scale was purchased for portable weights and the wheelchair scale has been moved to a more easily accessible area of the building. The RAs have been in-serviced (3/28/18) on proper weighing strategies including the use of consistent times of day, apparel, scale and technique. Weekly weights are now completed on Monday and Tuesday of each week and presented to the DON by Wednesday for review at the At Risk meeting during which the IDT will review and develop interventions as appropriate. Weights are to be entered in the resident□s clinical record in PointClickCare within 24 hours of taking them to assure the physician, dietician and IDT have access to make decisions and establish interventions timely. Monthly weights are required to be completed by the 5th of each month and are recorded in

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F 692	Continued From page 23 admitted from the hospital. Current diet was regular. Oral intake usually good and fed self. Height was 59", weight was 115 lbs., BMI (Body Mass Index) 23.2 and within normal limits. Current estimated nutritional needs: calories 1306 -1506, protein 53 - 64 grams, fluids 1800 milliliters plus. Labs noted and skin intact. Resident on weekly weights for 4 weeks. Agree with current plan. Will continue to monitor oral intake, labs, and weights and adjust accordingly. Review of the physician progress note dated 2/12/18 for Resident #50 did not contain a weight for resident or address her current nutritional status. An observation of Resident #50 on 2/26/18 at 9:00 am revealed she was lying in bed with her breakfast meal in front of her. The resident had only consumed a few bites of the meal. Resident #50 would not answer any questions and stated to leave her alone. There were no staff members present with resident. An observation of Resident #50 on 2/27/18 at 2:00 pm revealed she was in bed with her lunch meal in front of her. There were 2 staff members present in the room. One stated the resident had not wanted to eat much since she come back from the hospital. Resident #50 had not consumed any of her meal and yelled out "leave her alone." A phone interview with the RD on 2/28/18 at 9:24 am revealed when she completed the most recent note for Resident #50 on 2/9/18 she did not have a current weight on the resident. The RD stated the facility should obtain a re-admission weight on residents when they	F 692	the resident□s clinical record by the 7th of the month. Nurse Managers have been in-serviced (on 3/23/18) to check the EHR for alerts indicating significant weight changes and bring the information to the At Risk meeting which is typically held weekly and includes IDT review of changes, alerts, triggers experienced by residents. Weight changes are presented to the nursing team at the clinical meeting for a team approach to interventions. This meeting is typically held 5 days per week. Additionally, the Director of Nursing will review the weight list on a weekly basis to identify residents with weight changes to implement timely intervention. The Registered Dietician will also review weights on at least a monthly basis and make recommendations about interventions to improve the stability of residents□ weights. The Dietary Staff has been in-serviced on correct portioning on 3/15/18 with illustrations of the correct scoop to use based on dietary order, correct sizing of meats, management of double portions and extras for those resident with either a stated preference or an order. Weight loss data will be presented monthly (beginning April 26th) ongoing to the QAPI team specifically as well as with review of triggering quality measure data in the interest of achieving lasting process improvement opportunities. The QAPI team will also coordinate this data with audit data from the Dietary Manager who is tracking correct portioning and accuracy of meal trays. The team will continue to	

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F 692	Continued From page 24 come back from the hospital. She explained sometimes a weight would be done but not put in the EMR and she had to try and hunt down the weights. The RD could not recall if she had tried to locate a more updated weight on the resident. An interview on 2/28/18 at 12:00 pm with the Regional Nurse (RN) revealed she had located an additional weight in the weight book for Resident #50. The weight was obtained on 1/24/18 as 98 lbs. She added the resident had not been weighed again when she was re-admitted to the facility on 2/8/18 and they were obtaining a weight today. During an interview on 2/28/18 at 1:15 pm with the RN she stated they had obtained Resident #50 ' s weight today and she weighed 89 lbs. The RN acknowledged that the resident had experienced a 26 lb. / 22% weight loss from 1/2/18 to 2/28/18. She stated the resident should have been weighed when she was re-admitted but the facility had been staffed with agency and things had been missed. The RN explained the RD had availability to the weight of 98 lbs. on 1/24/18 because she was supposed to be provided with the weight book during her visits. She added it was her expectation that the RD would have checked the weight book for an updated weight because it may not have been put it the computer yet. An interview with the RN on 2/28/18 at 2:52 pm revealed the facility had turnover in the restorative aide (RA) who had obtained the weights. She stated the RA was supposed to provide the weights to the RD to approve and then the RD was supposed to put them in the computer. The RN explained all residents that were admitted or	F 692	move toward a larger process improvement goal of an enhanced dining program. The Administrator is responsible for sustaining compliance with this corrective action which will be implemented by March 28, 2018.	

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F 692	Continued From page 25	F 692		

re-admitted should be weighed within 24 hours of admission and weekly for the first 4 weeks of their admission. All residents were then supposed to be weighed monthly by the 15th of the month. The RN added Resident #50 should have been weighed when she was re-admitted to the facility and had weekly weight monitoring for the next 4 weeks. She stated it was her expectation that residents with weight loss would be assessed by the RD, the physician and discussed at the daily clinical meeting.

2. Resident #179 was admitted to the facility on 10/11/17 and diagnoses included vascular dementia with behavioral disturbances, dysphagia and cerebral vascular accident (CVA) affecting right side.

A quarterly minimum data set (MDS) dated 1/9/18 for Resident #179 identified his weight was 125 pounds (lbs.), had not experienced a significant weight change, received a mechanically altered diet, required supervision with eating and had impaired cognition.

A care plan dated 1/30/18 for Resident #179 stated resident was ordered a mechanically altered diet. The resident will continue to enjoy his prescribed diet without any nutritional complications through the next review. Interventions included to assist with meals as needed, observe for any chewing / swallowing issues, provide alternate meal if requested and refer to the Registered Dietitian (RD) as needed for nutritional consultation.

A review of the electronic medical record (EMR) for Resident #179 revealed his weights were: 124 lbs. on 2/2/18, 125 lbs. on 1/3/18 and 132 lbs. on

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	345131	A. BUILDING ______ B. WING ______	C 02/28/2018

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F 692	Continued From page 26	F 692		

12/9/17. There was an entry with the 1/2/18 weight of 125 lbs. that stated - (negative) 5% change over 30 days (comparison weight 12/9/17, 132 lbs., -5.3%, -7 lbs.)

Review of a nutrition note written by the RD dated 1/11/18 for Resident #179 stated resident seen for a quarterly nutrition assessment. Current diet is puree with nectar thickened liquids. Oral intake usually good and feeds self. Height was 61", weight was 125 lbs., BMI (Body Mass Index) was 23.6 and within normal limits. 5 lb. loss over 3 months. Labs noted and skin intact. Agree with current diet. Will continue to monitor oral intake, labs and weights and adjust accordingly.

Review of a weight change note by the MDS nurse dated 1/12/18 for Resident #179 stated 5% weight loss in 30 days. New order to add double portions, recent tracking of 75 to 100% of meals over the last 2 weeks. Continue observation. The MDS nurse was not available for an interview during the survey.

Review of the February 2018 physician orders for Resident #179 identified his diet order was regular, puree with nectar thickened liquids. There was no order for double portions.

Review of the meal card for Resident #179, provided by the Dietary Manager (DM) #2 revealed he was supposed to receive double portions of a puree diet and nectar thickened liquids.

An observation on 2/25/18 at 1:00 pm revealed Nursing Assistant #5 served Resident #179 his lunch meal. She placed the meal tray in front of the resident who was in bed. The meal tray

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F 692	Continued From page 27	F 692		

contained a small scoop of pureed ham, a small scoop of mashed potatoes, a small scoop of a light brown food and a glass of nectar thickened cranberry juice. Resident #179 immediately began eating and NA #5 left the room.

An interview and observation on 2/25/18 at 1:02 pm with NA #5 of Resident #179 identified the resident was missing some items from his tray. NA #5 stated it looked like they didn ' t serve him any bread or dessert. She added they sometimes don ' t serve residents bread. NA #5 did not identify that Resident #179 had not received double portions.

An observation of Resident #179 on 2/27/18 at 8:30 am revealed he was sitting up in bed with his breakfast meal in front of him. The meal tray contained a small scoop of pureed eggs, a small scoop of a light brown food, a bowl of oatmeal approximately ½ full and a glass of nectar thickened cranberry juice. There were no staff members present with resident. Resident #179 yelled out that he wanted some peanuts.

A phone interview with the RD on 2/28/18 at 9:45 am revealed she wasn ' t sure why she had documented Resident #179 had a 5 lb. weight loss over 3 months versus a 5% weight loss in one month. She stated she had probably looked back at his overall weight status and his BMI and that is why she hadn ' t recommended any nutritional interventions for the resident.

During an interview with DM #2 on 2/28/18 at 11:45 am she stated according to Resident #179 ' s meal card he was supposed to receive double portions of his puree diet. She added it was her expectation that the double portions would be

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	345131	A. BUILDING ____ B. WING ____	C 02/28/2018

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F 692	Continued From page 28 served as identified on his meal card. An interview on 2/28/18 at 11:50 am with the Director of Nursing (DON) revealed residents with weight loss were discussed in the daily clinical meeting. She stated new interventions for weight loss should be added and their care plans should be updated. The DON added she could not recall discussing weight loss for Resident #179.	F 692		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		3/28/18

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F 761	Continued From page 29 by: Based on observation and staff interviews the facility failed to dispose of open expired lab tubes for3 of 3 medication rooms, expired tube feeding for 1 of 3 medication rooms, expired insulin syringes for 1 of 3 medication rooms and expired IV solution bags for 1 of 3 medication rooms. Findings included: An observation of the 100 hall medication room occurred on 2-27-18 at 9:00am revealing the following items out of date; 4 open-purple top lab tubes with an expiration date of 10-31-17, 78 open yellow top lab tubes with an expiration date of 11-30-17 and 4 insulin syringes with an expiration date of 10-10-17. During an interview with nurse #1 she revealed that she could not state whether these items had been used past the expiration date because the items were still on the shelf to be used. The medication room on the 200 hall was observed on 2-27-18 at 7:50am revealing 20 open expired purple top lab tubes with an expiration date of 11-30-17. Nurse #3 stated that she was not sure if the tubes had been used since they were on the shelf with the other lab tubes. The 300 hall medication room was observed on 2-27-18 at 9:15am revealing the following items to be expired; 4- 0.9% sodium chloride IV solution 100ML with an expiration date of 07-17, 1- 5% dextrose solution 250ML IV with no readable expiration date, 1- 1800 calorie Nepro tube feeding 1.1QT with an expiration date of 2-1-18 and 59 open yellow top lab tubes with an expiration date of 11-30-17. Nurse #2 stated she	F 761	F761 Why and How deficient practice occurred: Medications and supplies must be regularly inspected for dates and current resident needs and those that are outdated, discontinued or otherwise no longer needed are to be disposed of properly. Many medications are returned to the pharmacy while other supplies may be disposed of or returned to other sources. A breakdown in staff responsibilities allowed this deficiency to occur. This has been remedied as will follow. Response to individual Component: The immediate/individual response was to remove and dispose of outdated laboratory supplies and insulin syringes found in the 100 hall med room; to dispose of outdated laboratory supplies found in the 200 hall med room; to immediately dispose of IV supplies, outdated lab supplies and outdated Nepro as well as package, document and return medications that were outdated or discontinued found in the 300 hall med room. These corrective actions were completed on 2/27/2018. Response to Systemic Component: To assure a system is in place to prevent reoccurrence, Unit Managers were added for each hall and were in–serviced on 3/23/2018 for correct procedures for storage, return and disposal of medications and supplies. -11-7 Nurses	

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F 761	Continued From page 30 did not realize the items mentioned had expired. An interview with the Administrator occurred on 2-28-18 at 5:05pm. The Administrator stated she expected all medications and supplies to be logged in and returned either to the pharmacy or the lab if out of date.	F 761	have been delegated responsibility and in-serviced on proper procedures for storage, disposal, return of medications and supplies. Additionally, each medication room is scheduled for weekly thorough review and cleaning by the unit manager or her assignee. -While every nurse is expected to check for and remove outdated or discontinued medications from the medication carts, each medication cart is scheduled for weekly thorough check by the Unit Manager for outdated, discontinued or discharged medications. - In addition, and as a final check, the DON will randomly inspect each medication cart and each medication room at least one time per week. Monitoring to prevent recurrence: Audit tools used to collect data from these checks will be reviewed during the clinical review and at risk meetings to look for opportunities to improve the systems. Individuals identified as not complying with systems will be re-educated with progressive discipline as needed. Audits and progress toward 100% compliance will be reviewed during the QAPI meeting beginning with the April meeting and continuing through the year. When audits indicate 6 months of 100% compliance, the QAPI committee will review and determine appropriate response. The DON is responsible for ongoing monitoring and sustaining compliance with this corrective action which was implemented as described by 3/28/18.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store food in sealed, labeled and dated containers, failed to allow dishes to air dry before being stacked together and failed to maintain kitchen equipment, walls and ceiling vents clean and in good repair. This was evident in 2 of 2 kitchen observations. Findings Included: 1. An observation of the kitchen on 2/25/18 at 11:00 am with Dietary Manager #1 (DM) revealed the following: a. The walk-in freezer contained the following cases of food that were not sealed, labeled, dated and were exposed to the air: a case of breaded	F 812	All food must be properly stored in appropriate containers at correct temperatures. Well trained staff will understand how to properly seal, label and date and store containers. Staff will understand that dishes washed must be allowed to air dry prior to stacking and storing. Staff will know how to sufficiently clean all equipment prior to and after using to allow it to be clean and dry for the next occasion of use. Inexperienced staff failed to meet this standard and require additional training and oversight. The walk in freezer has been thoroughly cleaned and all food products disposed of that are improperly labeled, sealed or	3/28/18

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F 812	Continued From page 32 fish fillets, a case of sliced zucchini, a case of hamburger patties, a case of bulk pre-made pancakes and a case of mixed vegetables. b. The walk-in refrigerator had 2 pitchers that contained thick, milky type liquid that were not labeled or dated. A large case of chocolate chips that showed evidence of melting and a loaf of sliced cheese that were not labeled or dated. A roll of thawing ground beef was on the bottom shelf with no label or date and had a red substance dripping onto the walk-in cooler floor. c. 40 insulated plastic plate holders were stacked together wet on a shelf ready to use for lunch service. e. The convection oven had black burned on food substances on the interior walls, bottom and oven racks. f. The counter top mixer had a dark brown substance on the exterior of the bowl and the base of the mixer. g. The exterior of the walk-in refrigerator and walk-in freezer had food spills on the wall. An interview on 2/25/18 at 11:22 am with Cook #1 revealed he wasn ' t sure when the convection oven was cleaned and it was supposed to be done by the second shift. An interview on 2/25/18 at 11:30 am with DM #1 revealed she had just been promoted from a Dietary Aide to the Dietary Manager. She stated all foods should be sealed when stored and be labeled. DM #1 added all equipment and walls should be clean. She stated she couldn ' t get the mixer to work but someone on second shift must have gotten it to work and not cleaned it. She stated the plastic plate holders were supposed to be allowed to air dry before being put away.	F 812	stored. All dishes have been rewashed and sanitized and placed on the new drying rack. Staff was in-serviced on 3/13/18 to understand the importance of allowing dishes to completely air dry prior to stacking or storage. Staff has been in-serviced to understand that meal trays also have to be allowed to air dry prior to stacking or use. Although the convection oven had been thoroughly cleaned on March 21 and 22, we have replaced this oven with a newer and upgraded model. The counter top mixer has been thoroughly cleaned on February, 28, 2018. The exterior of the walk in freezer has been thoroughly cleaned as of February, 28, 2018. The vents in the kitchen have been thoroughly scrubbed and rehung as of March 20, 2018. A cleaning schedule has been created and posted on 3/28/18 and staff was in-serviced on 3/28/18 on the schedule assuring all equipment is properly cleaned on a consistent and timely basis. The Dietary Manager Consultant began on 3/1/18 and initiated an audit that includes food temps, air drying, proper labeling and dating. The Dietary Manager Consultant began working closely with the dietary staff starting 3/1/18, teaching them proper sanitation strategies and regulations and auditing daily (5 days a week) to assure correct completion. Dietary Manager will complete daily (5 days a week) rounds using monitoring checklist to validate completion to assure	

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F 812	Continued From page 33 An interview on 2/26/18 at 4:03 pm with DM #2 revealed she was the interim DM and DM #1 ' s official start date for that positon was 3/1/18. DM #2 stated she was covering the position and training DM #1. She added the Registered Dietitian (RD) came to the facility 1 day per week to complete the nutritional documentation. DM #2 stated the facility had ordered new drying racks for the insulated plate covers and they arrived today. 2. An observation of the kitchen on 2/27/18 at 11:35 am with DM #2 revealed the following: a. 2 ceiling vents were covered with dirt and dust. b. Dietary Aide #1 was observed to be wiping water off the meal trays with a paper towel during the lunch meal service. Dietary Aide #1 stated they were wet. 21 meal trays were identified to be stacked together wet ready for the lunch meal service. An interview on 2/27/18 at 1:25 pm with DM #2 revealed she had tried to clean the ceiling vents and they started breaking apart when they were being scrubbed. DM #2 added that the meal trays should have been allowed to air dry before being stacked together. An interview on 2/28/18 at 4:41 pm with the Administrator revealed she expected all foods to be stored in a sealed containers with a label and date. She added all kitchen equipment should be clean and in good repair. The Administrator stated it was her expectation that dishes be allowed to air dry before they were put away.	F 812	sustained compliance. Audit tools will be presented to QAPI beginning with the April meeting and continuing for a six month period at which time the QAPI team will review and determine the need to continue. The Administrator is responsible for this corrective action which will be fully implemented by March 28, 2018.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/28/18

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F 880	Continued From page 34	F 880		

§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:

§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,

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F 880 Continued From page 35 F 880

depending upon the infectious agent or organism involved, and
(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, and staff interviews, the facility staff failed to follow contact precautions when providing care to 1 out of 1 resident (Resident #3) including wearing personal protective equipment when entering the room to provide care.
Findings include:
Resident #3 was admitted to the facility on 10/20/17 with diagnoses that include Encounter for Other Specified Aftercare, Dysphagia, Chronic Systolic Congestive Heart Failure, Enterocolitis due to Clostridium Difficile, and Diabetes Mellitus.

F880
Why/How did this deficient practice occur?
Staff failed to comply with the signs on the doors directing them to take contact precautions upon entering and exiting the room in which a patient was isolated related to c.dif. When questioned, the staff persons admitted they thought they could enter without protective equipment if they were not going to provide direct care or would be quickly in and out.

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F 880	Continued From page 36 A review of Resident #3's medical record revealed a nursing note dated 12/8/17 at 6:30 am that reported resident continues on contact precautions due to clostridium difficile. Resident #3's most recent MDS (Minimum Data Set) dated 12/9/17 was coded as a 30-day Medicare assessment. The MDS coded the active diagnoses as Heart Failure, Hypertension, Diabetes Mellitus, Hyperlipidemia, Encounter for other specified aftercare, Dysphagia, and Enterocolitis d/t clostridium difficile. An observation was made on 2/25/18 at 12:00pm that Resident #3 was on contact precautions with sign on door to gown and glove prior to entering room. Gowns and gloves were on the cart outside the resident's door. An observation was made on 2/26/18 at 1:11pm of Aide #6 entering Resident #3's room without gowning or gloving prior to entering the room. An observation was made on 2/27/18 at 3:19pm of Aide #7 entering the room of Resident #3 without gowning or gloving prior to entering the room. An interview with Aide # 6 was conducted on 2/26/18 at 1:22pm. Aide # 6 reported that when a resident is on contact precautions, staff is supposed to gown and glove prior to entering the resident's room. The staff is to remove the gown and gloves prior to leaving the room and wash hands with soap and water. The aide reported she should have gowned and gloved prior to entering Resident #3's room. The aide reported she didn't know why she didn't gown and glove. An interview with Aide #7 was conducted on 2/27/18 at 3:30pm. The aide reported that when a resident is on contact precautions, the staff should gown and glove prior to entering the room to care for the resident. He reported the staff should remove the gown and gloves and wash	F 880	Immediate Response for Individual(s): The staff persons who entered the room without protection were re-educated when the facility staff became aware of what happened. One of which was pulled aside and re-educated immediately. Each was informed about the absolute requirement of protective wear and devices for their own protection as well as the other residents they care for. The equipment and signage was reviewed with each and each was counseled that this could not occur again. Systemic Correction All staff was in-serviced on the requirement that they not enter the room without donning the protective gear that is outlined on the sign on the door on 3/28/2018. In addition, they are instructed to remove the gear and place it in the red disposal bag/box placed directly next to the door prior to exiting 3/28/2018. At exit, they are to use hand sanitizer and proceed to a handwashing station for a full handwashing on 3/28/2018. The facility provides signage as required by CDC/SPICE and follows the standards set by those organizations to prevent spread of infection. The facility provides a cart containing the protective gear outlined on the sign and selected based on the type of isolation the resident is requiring. To reinforce learning and compliance, on 3/28/2018 a sign was placed on the resident's door that states they may not enter the room until they have participated in the read and sign in-service that was placed at the nurse's station. The read and sign in-service	

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F 880	Continued From page 37 hands prior to leaving the room. He reported he should have gowned and gloved prior to entering Resident #3's room on 2/27/18. The aide reported "I made a mistake and it won't happen again". An interview with the Administrator was conducted on 2/28/18 at 10:15am. She reported it is her expectation that all staff follow contact precautions when caring for a resident on contact precautions.	F 880	reiterates the process of donning appropriate gear and removing it at exit and requires a signature acknowledging information and understanding on 3/28/2018. A Unit Manager has been assigned to each unit and has been trained to observe staff to assure compliance with these infection prevention standards. The Unit Manager is responsible to assure staff do not enter without protective gear and remove that gear prior to exiting the room. In the absence of the Unit Manager, each nurse has been informed of this responsibility and the importance of adherence to this policy. Monitoring The Staff Development Coordinator has met the SPICE/CMS requirements for Infection Preventionist and is responsible for overseeing isolation precautions and related staff training. The SDC will monitor each resident room under isolation precautions and observe staff entering and exiting at least three times a week. In addition, as an infection of concern is identified, staff training is reinforced and monitored for compliance. Further, SDC will monitor all infections in the building in real time to assure there is no spread of infections for the risk meeting which is typically held 1 time a week and the clinical meeting held 5 times a week. This monitoring is critical to understanding what risks are associated with resident care and assuring proper management to avoid spread. Any identified non-compliance will be dealt with rapidly with re-education and	

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F 880	Continued From page 38	F 880	progressive discipline as needed. QAPI Data about infections is presented at the QAPI meeting beginning with the April meeting and ongoing thereafter. The infection preventionist report will include data from the real-time monitoring to determine spread of infections and actions required to prevent spread and improve the process. The Director of Nursing has Ultimate responsibility for sustaining compliance with this corrective action which is complete by 3/28/2018.	