STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 08/01/2018

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ACCORDIUS HEALTH AT LEXINGTON	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		8/23/18

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

Electronically Signed | 08/23/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident's responsible party when a resident's pressure ulcer increased in size for 1 of 4 sampled residents reviewed for pressure ulcers (Resident # 1). The findings included: Resident # 1 was admitted to the facility on 02/18/2017 with diagnoses including but not limited to: end stage renal disease dependent on dialysis, diabetes, congestive heart failure, dysphagia, Alzheimer's Disease, and hypothyroidism. Review of a significant change Minimum Data Set (MDS) assessment dated 04/02/2018 revealed the resident was moderately cognitively impaired. The assessment indicated Resident # 1 required extensive assistance for bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. Resident # 1 was coded as not having any pressure ulcers at the time of the assessment. Resident # 1 was coded as being at risk for developing a pressure ulcer. A review of a skin assessment dated 06/23/2018	F 580	Process that lead to the deficiency: The alleged non-compliance occurred when the facility failed to notify resident #1 responsible party of the increase in measurements of the pressure ulcer. Correction for specific deficiency cited: Resident #1 was discharged from facility on 7-11-18. An audit of current residents with pressure ulcers was completed on 8-10-18 to ensure responsible parties had been notified of any change to a resident's pressure ulcer. Monitoring process and systemic changes to ensure plan of correction is effective: The licensed nursing staff were re-educated by the Director of Nursing on 8-8-18 regarding notification of Responsible Party when any changes occur with a pressure ulcer. This occurred on 8-8-18.	

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F 580	Continued From page 2 revealed that Resident # 1 had a new pressure area to his sacrum. The wound measured 5.5x3.5x0.3 cm. The note indicated that Resident # 1's responsible party (RP) and the facility Nurse Practitioner were present in the room when the wound was discovered and were aware. Review of the wound assessment, completed by Wound Nurse # 2, dated 07/03/2018 revealed the sacral wound measured 11x6xunstageable and was now 100% eschar. No odor was noted. Drainage was present, and the wound was being treated with Santyl. There was no documentation to indicate the RP was made aware of the change in the wound. The facility nurse practitioner and the wound doctor were made aware. Review of the wound assessment, completed by wound nurse # 2 on 07/11/2018 revealed the sacral wound measured 11.7x7xunstageable. The wound was described as dark, brown leather like eschar that was firm. Purulent drainage was noted to be coming from the wound right above the anus. The physician was made aware and a new order was obtained for Dakin's solution. There was no documentation to indicate the RP was made aware of the change in the wound. An interview conducted with Wound Nurse # 2 (WN # 2) via telephone on 07/31/2018 at 11:11 am revealed that Resident # 1 had a pressure ulcer on his sacrum. WN # 2 revealed that the wound was unstageable due to eschar. WN # 2 indicated that the wound rapidly increased in size in just a few days. WN # 2 indicated that it would have been his responsibility to notify Resident # 1's family that his wound had gotten worse. WN # 2 indicated that Resident # 1's responsible party (RP) did not know that the wound had gotten	F 580	Weekly audits will be conducted to review current residents with pressure ulcers to determine if any changes are documented and if so was the responsible party notified. This audit will be completed by the unit managers weekly times 8 weeks and then monthly times 1 month. Effective 8-31-18 the MDS Coordinator and the Director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assurance and Performance improvement Committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party: Effective 8-10-18 the Administrator and Director of Nursing Services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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F 580	Continued From page 3 worse. WN # 2 indicated that he recalled trying to reach Resident # 1's RP when the wound increased in size on 07/03/2018 but did not reach the RP. WN # 2 indicated that he was not able to leave a voice mail message for the RP at that time. WN # 2 further revealed that he had expected to see the RP in person at the facility later that day but did not. WN # 2 indicated that he must have forgotten about contacting the RP and he does not remember attempting to contact her after 07/03/2018. WN # 2 indicated that when the wound changed on 07/11/2018 and he got new orders he intended to contact Resident # 1's RP after he returned from dialysis. WN # 2 indicated that the resident was sent to the hospital from dialysis and did not return to the facility, so he had not spoken with the RP. WN # 2 revealed that his usual process was to contact the RP to notify them if a resident's wound changed or if orders were changed so they would be aware of what treatment was being provided and why. An interview conducted with the Director of Nursing on 08/01/2018 at 12:01 pm revealed that it would be her expectation that when Resident # 1's wound worsened that his family would have been made aware of the change in his condition. An interview conducted with the Administrator on 08/01/2018 at 12:48 pm revealed that it would be his expectation that if there was a significant change in a resident's condition, such as their wound worsened, it would be his expectation that staff reach out to the family to notify them.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 08/01/2018

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F 656	Continued From page 4 §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 plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 5 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a comprehensive care plan to address pressure ulcers for 2 of 4 residents reviewed for pressure ulcers (Resident # 1 and Resident # 4) The findings included: 1. Resident # 1 was admitted to the facility on 02/18/2017 with diagnoses including but not limited to: end stage renal disease dependent on dialysis, diabetes, congestive heart failure, dysphagia, Alzheimer's Disease, and hypothyroidism. Review of a significant change Minimum Data Set (MDS) assessment dated 04/02/2018 revealed Resident # 1 was coded as not having any pressure ulcers at the time of the assessment. A review of Resident # 1's care plan most recent care plan, dated 05/29/2018, revealed no care plan to address the resident's pressure ulcer. The care plan did address the resident being at risk for skin breakdown due to Alzheimer's dementia with the potential for decline, limited mobility, episodes of incontinence, nutritional risks, psychotropic medication, and weight loss. Review of a skin assessment, completed by Wound Nurse # 1 on 06/23/2018 revealed that Resident # 1 had a new pressure area to his sacrum. The wound measured 5.5x3.5x0.3 cm. Review of the wound assessment, completed by	F 656	Process that lead to the deficiency: The alleged noncompliance occurred when the MDS nurse and wound care nurse failed to develop a comprehensive care plan for pressures ulcers for resident #1 and resident #4. Correction for specific deficiency cited: Resident #1 was discharged on 7-11-18 On 8-1-18 the current MDS Coordinator and the wound care nurse reviewed and revised the current care plan for resident #4 to reflect the current status of his skin. Current residents with pressure ulcers were reviewed by the MDS Coordinator and the wound care nurse on 8-9-18 and the care plans were reviewed and revised. On 8-10-18 the MDS Coordinator and wound care nurse were re-educated on reviewing and revising the care plans with changes in pressure ulcers. The monitoring processes and systemic changes to ensure plan of correction is effective: On 8-10-18 the Director of Nursing and MDS Coordinator completed an audit of residents currently in the facility. The audit tool identified residents with pressure ulcers. Care plans were reviewed and revised to indicate pressure ulcers and care for twelve residents. On	

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F 656	Continued From page 6 Wound Nurse # 2, on 07/03/2018 revealed the sacral wound measured 11x6xunstageable and was now 100% eschar. No odor was noted. Drainage was present, and the wound was being treated with Santyl. Review of the wound assessment, completed by Wound Nurse # 2, on 07/11/2018 revealed the sacral wound measure 11.7x7xunstageable. The wound was described as dark, brown leather like eschar that was firm. Purulent drainage was noted to be coming from the wound right above the anus. The physician was made aware and a new order was obtained for Dakin's solution. A physician's order written on 06/24/2018 revealed that Santyl ointment had been ordered and was to be applied to the sacrum daily for wound care. The wound was to then be covered with calcium alginate and a dry dressing. A physician's order written on 07/11/2018 revealed that Dakin's solution (a topical solution used to prevent or treat infection) had been ordered to be applied topically every day and night shift to the sacral/coccygeal wound for wound care. An interview was conducted with the MDS Coordinator on 07/31/2018 at 2:24 pm. After reviewing Resident # 1's care plan, the MDS Coordinator indicated that she did not see where Resident # 1's care plan had been updated to reflect that he had a wound. The MDS Coordinator indicated that if someone had brought it to her attention that the resident had a wound she would have updated the care plan. The MDS Coordinator indicated that it would be her expectation that if a resident had a newly	F 656	8-10-18 the regional MDS Coordinator educated the current MDS Coordinator on the requirements for developing a care plan and a process of reviewing new orders daily Monday thru Friday to identify those residents that have pressure ulcers to ensure that the current care plan is reflective of the resident current status. The MDS Coordinator will monitor the compliance of developing care plans on residents with pressure ulcers monthly times 3 months or until a pattern of compliance is maintained. Effective 8-31-18 the MDS Coordinator and the Director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of sustainable compliance is maintained. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in substantial compliance. Responsible party: Effective 8-10-18 the MDS Coordinator and Director of Nursing Services are responsible to ensure implementation of this plan of correction for this alleged noncompliance and to ensure the facility remains in substantial compliance.	

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F 656	Continued From page 7	F 656		

identified wound that the care plan would be updated to reflect this and Resident # 1's care plan was not updated to reflect his wound which was first observed by staff on 6/23/18. The MDS Coordinator indicated that it would have been the responsibility of the wound nurse, a unit manager, or herself to update the care plan.

An interview conducted with Wound Nurse # 2 (WN # 2) on 08/01/2018 at 8:44 am revealed that Resident # 1 had a pressure ulcer on his sacrum. WN # 2 revealed that the wound was unstageable due to eschar. WN # 2 indicated that the wound rapidly increased in size in just a few days. After reviewing Resident # 1's care plan, WN # 2 indicated that it did not appear the care plan was updated to reflect his pressure wound. WN # 2 revealed that the last time the skin break down section of the care plan had been updated was on 04/30/2018 and only reflected that Resident # 1 was at risk for skin break down. WN # 2 indicated that he was not certain who would be responsible for updating the care plan when a new skin issue was identified but he would assume it would be him since he was responsible for the wound department. WN # 2 revealed that it would be his expectation that if a resident had newly identified skin break down that their care plan would be updated to reflect this.

An interview was conducted with the Director of Nursing (DON) on 08/01/2018 at 12:01 pm. The DON reviewed the care plan for Resident # 1 and indicated that the care plan did not reflect that the resident had skin breakdown or pressure ulcers. The DON further indicated that the care plan only indicated that the resident was at risk for skin break down. The DON revealed that it would be her expectation that care plans be updated to

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F 656	Continued From page 8	F 656		

reflect the resident's skin break down.

2. Resident # 4 was readmitted to the facility on 06/25/2018 with diagnoses including but not limited to: hypertension, peripheral vascular disease, diabetes, end stage renal disease, and dependence on dialysis.

Review of a quarterly Minimum Data Set (MDS) assessment dated 07/19/2018 revealed the resident was moderately cognitively impaired. Resident # 4 required extensive assistance for bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. Resident # 4 was coded as having one Stage III pressure ulcer that was present on admission.

A review of Resident # 4's care plan most recent care plan, dated 07/26/2018, revealed no care plan to address the residents pressure ulcer. The care plan did address the resident being at risk for skin breakdown due to limited mobility, episodes of incontinence, narcotic medication, nutritional risks and oxygen tubing in use.

An observation of Resident # 4 was made on 07/31/2018 at 4:35 pm. Resident # 4 was noted to be sitting in his wheelchair in his room with his eyes closed. Resident # 4 was noted to have a pressure relieving cushion in his wheelchair and had a multipodus boot on his left foot.

A review of a skin assessment, completed by Wound Nurse # 2 on 06/26/2018 revealed that Resident # 4 had a pressure wound on his left heel that was present on admission. The wound measured 1.4x1.6x0.9 cm and was 25% slough.

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F 656	Continued From page 9	F 656		

A review of a wound assessment, completed by Wound Nurse # 2 on 07/03/2018 indicated that the left heel wound measured 1.7x2x0.5 and was 15% eschar.

A review of the weekly wound log for the week of 07/8/2018 indicated that the left heel wound measured 1.7x2x0.5 cm and was 15% eschar.

A review of a wound assessment, completed by Wound Nurse # 2 on 07/19/2018 indicated that the left heel wound measured 1.5x2x0.5 and was 15% eschar.

A review of the weekly wound log for the week of 07/22/2018 indicated that the left heel wound measured 1.7x1.8x0.5 and was 5% eschar.

Review of a wound consult note dated 07/31/2018 revealed that the wound had been debrided and measured 1.4x1.8x0.7.

An interview conducted with Wound Nurse # 2 (WN # 2) on 08/01/2018 at 9:41 am revealed that Resident # 4 was admitted with a wound on his left lateral heal. WN # 2 further revealed that Resident # 4 had impaired circulation to his left leg and only had a faint palpable pulse in the foot. WN # 2 indicated that the wound was probably a combination of venous/arterial insufficiency and pressure. WN # 2 indicated that Resident # 4 has had pressure ulcers since his admission, so his care plan should reflect that. After reviewing Resident # 4's most recent care plan, WN # 2 indicated that the care plan did not reflect that Resident # 4 had a pressure wound. WN # 2 indicated that it would be his expectation that the care plan should reflect that Resident # 4 had a pressure ulcer and the care that was being

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F 656	Continued From page 10 provided. An interview was conducted with the MDS Coordinator on 08/01/2018 at 10:28 am. The MDS Coordinator revealed that Resident # 4's care plan did not reflect his skin break down, only that he was at risk for break down. The MDS Coordinator further revealed that since Resident # 4 currently had skin break down she would expect the care plan to reflect this. The MDS Coordinator indicated that she was currently in the process of updating his care plan. An interview was conducted with the Director of Nursing (DON) on 08/01/2018 at 12:01 pm. The DON reviewed the care plan for Resident # 4 and indicated that the care plans did not reflect that the resident had skin breakdown or pressure ulcers. The DON further indicated that the care plan only indicated that the resident was at risk for skin break down. The DON revealed that it would be her expectation that care plans be updated to reflect the resident's skin break down.	F 656		