| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 001 SS=F | Establishment of the Emergency Program (EP)<br>CFR(s): 483.73<br><br>The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:<br><br>*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.<br><br>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop an Emergency Preparedness (EP) plan. The EP plan did not address the resident population to include residents at risk, the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials, the development of EP policies and procedures, the procedures for tracking residents and staff, evacuation procedures or sheltering procedures, procedures for medical documents, the procedures for | E 001 | E 001 Emergency Plan<br>• The plan for correcting the specific deficiency<br>The process that led to this deficiency was the Administrator and Maintenance Director failed to establish and maintain a comprehensive emergency preparedness (EP) plan.<br>On 10/22/18, the regional director of operations re-educated the administrator and maintenance Director related to | 10/26/18 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 10/19/2018 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 001 | Continued From page 1<br>volunteers, the arrangements with other facilities, the role of a facility using a waiver declared by the Secretary, a method of sharing information with the residents families/representatives, emergency officials contact information, a primary and alternate means of communicating, methods for sharing information, including occupancy and needs and family notifications, medical information for resident providers to maintain the continuity of care, the development of testing exercises or an emergency power system and emergency generator fuel.<br><br>Findings included:<br><br>Review of the facility ' s Emergency Preparedness plan material revealed:<br><br>A. The EP plan did not address the resident population including at-risk residents and the type of services the facility could provide in an emergency.<br><br>B. The EP plan did not address the procedures for EP collaboration with local, tribal, regional, state and Federal EP officials.<br><br>C. The EP plan did not develop EP policies and procedures for tracking residents and staff.<br><br>D. The EP plan did not develop policies and procedures for evacuation procedures or sheltering in place.<br><br>E. No plan was in place for a system of medical documentation which preserved patient information, protected confidentiality or secured records. | E 001 | development of a comprehensive EP plan which described the facilities comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation.<br>On 10/22/18, the administrator and maintenance director began development of a comprehensive EP plan which described the facilities comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. The facilities EP plan includes addressing resident population, process for EP collaboration, subsistence need for staff and residents, procedure for tracking of staff and residents, policies and procedures for medical records, policies and procedures for volunteers, arrangement with other facilities, development of a communication plan, names and contact information, emergency officials contact information, primary/alternate means for communication, methods for sharing information, sharing information on occupancy/needs, EP training and emergency power.<br><br>• Procedure for implementing the plan:<br>By 10/24/18 the director of operations will review the facility EP plan to ensure the facility plan included a comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 001 | Continued From page 2<br>F. No policies or procedures were in place for volunteers.<br><br>G. No policies or procedures were in place for arrangements with other facilities.<br><br>H. The role of the facility under a waiver declared by the Secretary was not defined.<br><br>I. There was no plan for communication.<br><br>J. There were no emergency officials contact information.<br><br>K. No methods for sharing information or medical documentation for the residents of the facility were in place.<br><br>L. There were no methods for sharing information on the facility occupancy or needs.<br><br>M. There were no methods in place for sharing information from the emergency plan with residents or family members.<br><br>N. There were no EP training and testing plans in place.<br><br>O. There were no integrated health system policies and procedures in place.<br><br>P. There was no plan in place for emergency power source or generator fuel.<br><br>The facility Administrator was interviewed on 9/26/2018 at 5:40 PM. She reported when the current organization took over the facility on 5/1/2018, the previous company removed all their agency specific information, including the | E 001 | ¿ The facility Administrator, and the maintenance director have reviewed, and updated our current manual, as of 10/24/18, to include:<br>A) Current facility risk population identified, including residents needing special care like oxygen and immobility and services the facility is capable of providing to residents during an emergency situation.<br>B) Collaboration with local, federal and state EP officials.<br>C) Process to track staff and residents if displaced<br>D) Shelter in place criteria for residents and/or staff who need to remain in the facility in the event evacuation could not occur<br>E) Maintaining confidentiality of resident medical records during an evacuation or transfer to another facility, during an emergency.<br>F) Process to utilize volunteers<br>G) Transfer arrangements with other facilities<br>H) A defined role under a waiver declared by the secretary<br>I) Communication Plan, including name, contact information for all staff working in the facility, contact information of resident's attending physician, and contact information of facilities available to provide care and services to residents in an emergency.<br>J) To include emergency officials contact information<br>k) Communication plan to include how resident information and medical documents will be shared with other | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 001 | Continued From page 3<br>emergency plan and the Administrator was not aware the EP book that was in place was not complete. The Administrator reported it was her expectation the EP plan was put in place to meet regulations. The Vice President of Clinical Services was interviewed at the same time as the Administrator and she reported the management company did not have a corporate EP policy and a facility specific EP plan would need to be developed.<br><br>The Maintenance Director was interviewed on 9/26/2018 at 6:23 PM. The Maintenance Director reported he was responsible for the emergency plan and had been given that role on 5/1/2018. He was not certain if the previous management company had trained staff in Emergency Preparedness. He reported he thought having a generic book with policies and procedures that addressed various emergency scenarios was appropriate and he did not realize the EP book should be dynamic and updated with facility specific information. | E 001 | facilities and health care providers to ensure continuity of care.<br>L) To include communication of available beds<br>M) Communication plan to include how emergency plan information that is shared with facilities residents, family members and resident's representative.<br>N) A process for testing and training requirements of this plan.<br>O) To include integrated health system polices<br>P) Identified emergency power system that is in place in case of a power failure during an emergency situation.<br>The Safety Committee members, including the maintenance Director, Director of Nursing, Human resources, and the Administrator will educate the facility staff and residents, 10/24/18, on the updated information related to the Emergency Program.<br>• Monitoring procedure<br>¿ A review of the Emergency Preparedness manual will be conducted by the director of operations for compliance of Emergency prep testing and conduct any staff exercise to test their EP plan; Policies and procedures for sheltered residents and staff who remained in the facility; Policies and procedures to track resident and staff who were moved to other facilities; Contact information of staff, pharmacy, resident physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman; Procedures of sharing information and medical documentation of a resident with | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 001 | Continued From page 4 | E 001 | other health care providers that would be providing continuity of care; Method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency; Establishing a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives by completion 10/24/18 and Biannually X 2.<br>¿ The emergency plan will be evaluated annually by the Safety Committee to ensure the contents are current.<br>• Title of the person responsible for implementing the plan:<br>¿ Administrator<br>• Date the plan will be completed<br>¿ 10/24/18 | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 550 | Continued From page 5<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interviews the facility failed to treat a resident in a dignified manner, by allowing exposure through a window to a road and traffic while not being covered from the waist down and only wearing a brief, for 1 of 4 residents reviewed for dignity (Resident #77).<br><br>The findings included:<br><br>Resident #77 was admitted to the facility on 1/28/16 with diagnoses which included: Dementia, anxiety, and insomnia. | F 550 | F 550 Resident Rights<br>The plan for correcting the specific deficiency:<br><br>The alleged deficiency occurred when staff allowed exposure of resident #77 through a window to a road and traffic while not being covered from the waist down and only wearing a brief while a housekeeper cleaned the room. The blinds were immediately closed upon notification. Housekeeping staff and certified nursing assistants were re-educated on 10/24/18 regarding dignity | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 550 | Continued From page 6<br>Review of Resident #77's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) 8/14/18. Review of the assessment revealed the resident had severe cognitive impairment. The resident required was totally dependent for all Activities of Daily Living (ADLs) including: Bed mobility, transfer (such as from the bed to a wheelchair), maneuvering about the unit, dressing, eating, toilet use, personal hygiene, and bathing.<br><br>Review of Resident #77's care plan, which had been most recently revised on 9/5/18 revealed the following focus areas: Incontinent of both bowel and bladder, required extensive assistance with ADLs, dependent on staff for physical, emotional, intellectual, and social needs, and impaired cognitive function/dementia or impaired thought process related to dementia. Review of the care plan revealed no care plans or interventions related to disrobing or removing covering.<br><br>An observation was conducted of Resident #77 on 9/23/18 at 11:47 AM. The resident was observed to have been lying in bed and awake. The resident's legs were exposed, the resident was wearing a brief, the resident did not have a cover, sheet, or other linen covering him, and the resident did have a pillow with no pillow case pulled over his groin. There were two beds in the room and the resident was in the bed next to the window. There was a privacy curtain pulled obscuring the view of the resident from the bed by the door and the hallway. There was a window which had nothing to provide privacy to the resident from being viewed from the outside. There was a visible road from the resident's room | F 550 | of a resident and making sure the blinds are closed when a resident is exposed. Per resident #77's request, he prefers, and is care planned, to have on only a brief while in bed, and not be covered up.<br><br>Procedure for implementing the plan:<br><br>Starting 10/24/18 the Director of Nursing Services and or Staff Development Coordinator will complete education for current licensed nurses, certified nursing assistants, activity staff, housekeeping staff, dietary staff, and rehabilitation staff. This education will include, resident rights as it relates to dignity and exposure of a resident and keeping blinds closed and curtains drawn when a resident is exposed. Housekeeping staff will be re-educated about being in the room when patient care is being delivered. This education will be completed by 10/24/18. Any licensed nurses, certified nursing assistants, activity staff, housekeeping staff, dietary staff and rehabilitation staff not educated prior to 10/24/18 will not be allowed to work until educated. Effective 10/22/18 all new hire licensed nurses, certified nursing assistants, activity staff, housekeeping staff, dietary staff, rehabilitation staff will receive orientation regarding, resident rights as it relates to dignity and exposure of a resident and keeping blinds closed and curtains drawn when a resident is exposed.<br><br>Monitoring Procedure:<br><br>The Director of nursing, staff development | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 550 | Continued From page 7<br>and cars were seen traveling on the road. The road was approximately 30-40 feet from the window of the resident's room. The blinds for the window were in the all the way up position.<br><br>An interview was conducted with Nursing Assistant (NA) #1 on 9/24/18 at 3:29 PM. The NA stated the resident was unable to care for himself and was dependent on staff for incontinent care. The NA stated she was going to provide incontinent care for the resident. The NA did state the resident would throw his covers off at times but she checked on him and would cover him back up as needed.<br><br>An observation was conducted of Resident #77 on 9/25/18 at 11:39 AM. The resident was observed to have been lying in bed and awake. The resident was observed to have had on a brief and a shirt. The resident's legs were exposed. There was no sheet or other type of cover observed on the resident's bed. The privacy curtain dividing the door and the window bed was pulled which obscured the view of the resident from the hall. Housekeeper (HSK) #1 was observed to have had her housekeeping cart next to the door from the hall for Resident #77. HSK was observed going into and out of Resident #77's room including over to the side of the room where Resident #77 was. HSK #1 swept and mopped the room including the side of the room where Resident #77 was lying in the bed wearing a brief, a shirt, and having had nothing to cover him from his waist down. There was a window which had nothing to provide privacy to the resident from being viewed from the outside. There was a visible road from the resident's room and cars were seen traveling on the road. The road was approximately 30-40 feet from the | F 550 | coordinator, unit managers and manager on duty will complete a visual audit of residents to ensure they are not exposed and that blinds and curtains are drawn if a resident is exposed for 10 rooms a day for 2 weeks then 30 rooms a week for 2 weeks then 30 rooms a month for 2 months.<br>The Director of nursing will present the results of the visual audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance.<br><br>Title of person responsible for implementing this plan:<br>Director of Nursing<br>Administrator | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 550 | Continued From page 8<br>window of the resident's room. The blinds for the window were in the all the way up position.<br><br>An interview was conducted with HSK #1 at 11:41 AM. HSK #1 stated she was cleaning Resident #77's room.<br><br>An interview was conducted with Nursing Assistants (NA) #3 and NA #4 on 9/25/18 at 11:43 AM. The NA stated she was going to clean and provide incontinent care for Resident #77. The NA stated she did not know what had happened to the resident's top sheet. The NA stated she had not put a gown on the resident, but she had put a shirt on him. When the NA #3 and NA #4 entered the room NA#4 closed the blind in the window. NA#4 stated she had just closed the blind in Resident #77's room. NA #3 stated the resident had a history of taking his clothes off or picking at items.<br><br>An interview with HSK #1 was conducted on 9/25/18 at 11:47 AM. The HSK stated the resident's linens were in a bag when she had arrived in Resident #77's room. The HSK stated there was a bed pad and a sheet in the bag she removed from the room. The HSK stated there was not a sheet or other type of cover on the floor when she entered the room.<br><br>During an interview conducted with the Administrator on 9/26/18 at 4:29 PM she stated it was her expectation to either cover a resident or to close the blind on the window to protect a resident's dignity. | F 550 | | |
| F 584 SS=C | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7) | F 584 | | 10/26/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 9 | F 584 | | |

§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;

§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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 10<br>sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to maintain a clean environment for two of three halls (200 Hall and 300 Hall) reviewed for environment.<br><br>Findings included:<br><br>Review was conducted of a quote from a boiler repair/installation company to Accordius Health of Salisbury dated 8/1/18. The quote contained the information that due to the location of tank and water header piping on outside of the tanks away from the wall, additional man power is required to complete the work. The quote further explained an additional fee due to the extra labor involving 4 men and the associated trip charge. The quote was signed, but not dated, by the Maintenance Director (MD).<br><br>A review was completed of a proposal from a roofing and sheet metal contractor dated 9/13/18. The proposal contained information for a Job Name of New roof on section 26 feet by 41 feet (the size of the roof over the 300 Hall Dining Room). The proposal contained information to remove the old roofing where needed, install a new roof system over the old roof system, tie in the existing roofing on the sides, install pads for the HVAC to sit on, and install finish aluminum the sides. The proposal was signed as accepted on 9/24/18.<br><br>A review was completed of an email exchange thread from 9/21/18 through 9/23/18 on the emails provided. The emails detailed exchanges between the MD and the Director of Plant | F 584 | F 584 Safe/Clean/Comfortable/Homelike environment<br><br>The plan for correcting the specific deficiency<br><br>The alleged deficiency occurred when the facility failed to maintain a comfortable, homelike and functional environment as evidenced by stained ceiling tiles in room 307, nursing station on 300 hall, along with area between rooms 301, and 302, walls needing repair in rooms 310, 304 and 223. Hot and cold-water handles needing repair in room 304, and the toilet in need of repair in room 304. Closet doors off the track in rooms 307 and 314. Toilet paper holders need to be replaced in rooms 304 and 306. Floor tiles need repair at entrance into room 314, along with overhead light repaired and a foot board removed from room 306, and the boiler that is leaking. A maintenance repair request was completed for each item.<br><br>Procedure for implementing the plan<br><br>The maintenance director and staff development coordinator will re-educate by 10/26/18 licensed and non-licensed nursing staff, housekeeping, dietary, social services, rehabilitation and activity staff on how and when to complete a maintenance request form. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 11<br>Operations regarding the paperwork and subsequent start to repair the roof above the 300 Hall Dining Room. Review of the emails revealed no evidence of a signed contract for installation of a new roofing membrane.<br><br>An observation conducted on 9/23/18 at approximately 9:30 AM of the hall which exited to the employee smoking area revealed multiple linens placed on the floor against the bottom of the wall extending from the 100 Hall to the exit. The total length was approximately 16 feet.<br><br>An observation was conducted on 9/23/18 at 10:14 AM of the ceiling at and near the nurses' station. There were visible water spots, which had formed brown circles on the white ceiling tiles, on the ceiling above the nurses' station. The spots included the following: One softball sized, three basketball sized, and four beach ball sized. There were three ceiling tiles missing and two ceiling tiles which were broken. The broken and missing ceiling tiles exposed wires in the ceiling and Heating Ventilation Air Conditioning (HVAC) ductwork. Between rooms 301 and 302 there were two more beach ball sized brown colored water stains on the ceiling tiles.<br><br>An observation on 9/23/18 at 12:24 PM of room 307 revealed ceiling tiles in bathroom had water damage as evidenced by one tile was broken through exposing the ductwork in the ceiling and other tiles had brown water stains. The sliding closet doors were observed to have been off track and resting on the floor.<br><br>An observation on 9/23/18 at 11:00 AM of the bathroom in room 310 revealed a quarter sized hole in the bathroom behind the towel rack. | F 584 | The administrator will develop room round observations to be completed daily (Monday thru Friday) by the department heads to include the Director of nursing, Director of Rehabilitation, Certified dietary manger, social services, unit managers, activity director, and housekeeping director. Rounds will be completed by the manager on duty for weekends. These round sheets will be given to the administrator and discussed in the morning stand up meeting Monday thru Friday.<br><br>The maintenance director and administrator conducted visual rounds on each room to determine the following in each room, missing face plates for call bell system, hot and cold handles broken, toilets in need of repair, holes in walls, missing cove base, holes in lights, missing toilet paper holders, closet doors off tracks, floor tiles needing repair and over bed lights broken. Any item in need of repair was logged on a maintenance request and form and a date for repair assigned.<br><br>Monitoring Procedure<br><br>The administrator will visually audit 10 rooms a day for 2 weeks then 30 rooms a week for 2 weeks then 30 rooms a month for 2 months to ensure rooms are functional and needed repairs are completed timely and if rooms need repair this is logged on a maintenance request form.<br>The Administrator will present the results | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 12<br>There was a vertical seam in the wall paper which had become loose for about 18 inches above the over the bed light.<br><br>An observation on 9/23/18 at 3:04 PM of room 223 revealed repaired drywall behind the room door. Despite the repair, the door handle on the entrance door had damaged the wall and created another hole.<br><br>An observation on 9/23/18 at 12:30 PM of room 306 revealed the footboard was off of the bed by the door and it was leaning against the wall behind the door. One half of the toilet paper holder was missing. There were two holes between where the toilet paper holder should have been and the one which remained. In addition, there were two holes where the toilet paper holder was missing.<br><br>An observation on 9/23/18 at 11:49 AM of room 314 revealed the over the bed light for the bed by the window had a hole in the lens/cover which was approximately baseball sized. The mattress cover was unzipped on the left side exposing the foam. The sliding closet door was off of the track and the door was sitting in the closet.<br><br>An observation on 9/23/18 at 10:44 AM of room 305 revealed the cove base was missing from the base of the wall by the bathroom exposing damaged sheetrock.<br><br>An observation on 9/23/18 at 11:37 AM revealed damaged floor tile and pieces of floor tile missing on the floor in the hall at the entrance to room 314.<br><br>An observation of room 304 and an interview | F 584 | of the visual audits to the quality assurance performance committee (QAPI) monthly for 3 months for any recommendations or modifications. The QAPI committee can modify this plan to ensure the facility remains in compliance.<br><br>Title of person responsible for implementing this plan: Administrator | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 13 | F 584 | | |

were conducted on 9/23/18 at 10:28 AM. The observation revealed the hot and cold water handles for the sink in the bathroom did not turn and the water was coming out of the faucet at steady drip almost a pour. The toilet tank valve was cycling on and off about every 15 seconds. There were 3 holes in the wall next to the toilet paper holder and there was no cartridge in the holder to hold toilet paper. An observation conducted of NA #2 revealed she went attempted to fill a bath basin to bathe a resident. The NA stated the water did not come on from the hot or cold handles at the sink in the bathroom. The NA was able to get the cold water turned on and stated she needed hot water to bathe the resident. The NA left the room to get hot water to bathe the resident.

An observation conducted on 9/23/18 at approximately 5:30 PM of the hall which exited to the employee smoking area revealed multiple linens placed on the floor against the bottom of the wall extending from the 100 Hall to the exit. The total length was approximately 16 feet.

An observation conducted on 9/24/18 at approximately 8:15 AM of the hall which exited to the employee smoking area revealed multiple linens placed on the floor against the bottom of the wall extending from the 100 Hall to the exit. The total length was approximately 16 feet.

An observation conducted on 9/24/18 at 2:24 PM revealed several damaged and water stained ceiling tiles had been replaced above the nurses' station at the 300 Hall. Several brown stained ceiling tiles remained above the nurses' station ranging in size from golf ball sized to beach ball sized. One ceiling tile remained to be missing at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 14 | F 584 | | |

the rear of the nurses' station. The missing ceiling tile exposed visible wires above the ceiling.

An interview was conducted with Nurse #2 on 9/24/18 at 2:58 PM. The nurse stated she believed the spots on the ceiling at the 300 Hall nurses' station were from a leak. The nurse stated she had not filled out any work orders but she had talked to the maintenance person about things like a bed remote and the maintenance person would come and address it.

An interview and observation were conducted with Housekeeper (HSK) #1 on 9/24/18 at 3:09 PM. The HSK stated the stained ceiling tile in the hallway by room 329 was caused by the recent rain/hurricane. The HSK stated there had been some issues with the recent rain but she had not written any work orders for damaged ceiling tiles. The HSK stated if there was something which needed to be repaired, she would complete a work order, but if it was something urgent, such as a bathroom which was flooding, she would go and tell the maintenance person.

An observation on 9/24/18 at 3:26 PM of the bathroom in room 310 revealed a quarter sized hole in the bathroom behind the towel rack. There was a vertical seam in the wall paper which had become loose for about 18 inches above the over the bed light.

An observation of room 314 and an interview was conducted with Nursing Assistant (NA) #1 on 9/24/18 at 3:29 PM. The closet doors were observed to have been off of the sliding track and partially resting on the floor and there was an approximately baseball sized hole in the over the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 15 | F 584 | | |

bed light for the bed next to the window. The NA stated she had been working at the facility for approximately one month and had been working with the resident in that room frequently. The NA stated the closet door had been broken and the hold had been in the over the bed light since she had started working approximately one month ago.

An observation on 9/24/18 at 3:39 PM of room 223 revealed repaired drywall behind the room door. Despite the repair, the door handle on the entrance door had damaged the wall and created another hole.

An observation conducted on 9/24/18 at 3:45 PM of room 208 revealed the cove base to have been missing to the left of the bathroom door exposing damaged sheetrock.

An observation on 9/24/18 at 3:58 PM of room 307 revealed ceiling tiles in bathroom had water damage as evidenced by one tile was broken through exposing the ductwork in the ceiling and other tiles had brown water stains. The sliding closet doors were observed to have been off track and resting on the floor.

An observation on 9/24/18 at 4:01 PM of room 306 revealed the footboard was off of the bed by the door and it was leaning against the wall behind the door. One half of the toilet paper holder was missing. There were two holes between where the toilet paper holder should have been and the one which remained. In addition, there were two holes where the toilet paper holder was missing.

An observation of room 304 was conducted on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 16 | F 584 | | |

9/24/18 at 4:02 PM. The observation revealed the hot water handle for the sink in the bathroom did not turn and the water was coming out of the faucet at steady drip almost a pour. The toilet tank valve was cycling on and off about every 15 seconds. There were 3 holes in the wall next to the toilet paper holder and there was no cartridge in the holder to hold toilet paper. When the hot water valve was turned on, no water came out of the faucet.

An observation, round, and interview were conducted with the Maintenance Director (MD) on 9/24/18 starting at approximately 4:15 PM. Multiple brown stained ceiling tiles were observed at and near the nurses' station at the 300 Hall. An interview with the MD revealed the Salisbury area had received approximately 19 inches of rain from Hurricane Florence the previous weekend. The MD stated there had been multiple points where leaks from the roof had come through the suspended ceiling. The MD stated the water had gotten into the ductwork of the HVAC system and traveled throughout the 300 Hall but most of the leaks had occurred in the Dining room and at the Nurses' station for the 300 Hall. The MD stated he had been on the roof during part of the storm and there had been so much water, the drains on the flat roof were unable to handle the volume of water and some leaks had developed near the drains. An inspection of the roof revealed some visible impairments in the roof membrane above the dining room for the 300 Hall. The MD stated he was in the process of getting a repair approved for the membrane above the dining room but was awaiting a revision for a 15-year warranty. An additional observation was conducted of the three hot water holding tanks located in the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 17 | F 584 | | |

Maintenance office. There were multiple linens arranged around the hot water holding tanks and visible water on the floor. The MD stated the middle tank had been leaking and a company had come out to replace the middle holding tank. The MD further stated due to the unforeseen complexity of the repair the company conducting the replacement was postponed until a new quote could be obtained for additional man hours to complete the repair. The MD stated the new holding tank was at the facility but he was still awaiting the replacement to be completed. The MD stated he had been putting the linens in the hallway or in the maintenance office daily about the past two months.

An observation conducted on 9/24/18 at approximately 5:00 PM of the hall which exited to the employee smoking area revealed multiple linens placed on the floor against the bottom of the wall extending from the 100 Hall to the exit. The total length was approximately 16 feet.

An observation conducted on 9/25/18 at approximately 8:15 AM of the hall which exited to the employee smoking area revealed multiple linens placed on the floor against the bottom of the wall extending from the 100 Hall to the exit. The total length was approximately 16 feet.

An observation conducted on 9/25/18 11:12 AM of room 307 revealed ceiling tiles in bathroom had water damage. One tile was broken through exposing the ductwork in the ceiling. Both closet doors were observed to have been off of the track.

An interview was conducted with Unit Manager (UM) #1 on 9/25/18 at 11:13 AM. The UM stated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 18 | F 584 | | |

the ceiling tiles on the 300 Hall were damaged during the hurricane due to having had a lot of rain. The UM stated some of the ceiling tiles had water stains from rain when there was a lot of rain prior to the hurricane. The UM stated when there are rain storms the ceiling leaked. The UM stated the MD had a box by the maintenance office for work orders and they had a box at each unit they could put work orders into. The UM stated there was a manager meeting each morning Monday through Friday and the work orders were reviewed during the meeting.

An observation of room 304 was conducted on 9/25/18 at 11:29 AM. The observation revealed the hot water handle for the sink in the bathroom did not turn and the water was coming out of the faucet at steady drip almost a pour. The toilet tank valve was cycling on and off about every 15 seconds. There were 3 holes in the wall next to the toilet paper holder and there was no cartridge in the holder to hold toilet paper. When the hot water valve was turned on, no water came out of the faucet.

An observation on 9/25/18 at 11:32 AM of room 306 revealed the footboard was off of the bed by the door and it was leaning against the wall behind the door. One half of the toilet paper holder was missing. There were two holes between where the toilet paper holder should have been and the one which remained. In addition, there were two holes where the toilet paper holder was missing.

An observation on 9/25/18 at 11:34 AM of the bathroom in room 310 revealed a quarter sized hole in the bathroom behind the towel rack. There was a vertical seam in the wall paper which

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 19 | F 584 | | |

had become loose for about 18 inches above the over the bed light.

An observation on 9/25/18 at 11:36 AM of room 314 revealed the over the bed light for the bed by the window had a hole in the lens/cover which was approximately baseball sized. The mattress cover was unzipped on the left side exposing the foam. The sliding closet door was off of the track and the door was sitting in the closet.

An observation, round, and interview was conducted with the MD on 9/25/18 at 3:38 PM. The following was observed during the round: An observation of room 208 revealed the cove base was missing from the wall to the left of the bathroom door, which exposed damaged sheetrock. An observation of room 307 revealed ceiling tiles in bathroom had water damage as evidenced by one tile was broken through exposing the ductwork in the ceiling and other tiles had brown water stains. The sliding closet doors were observed to have been off track and resting on the floor. An observation of room 306 revealed the footboard from the bed by the door was leaning against the wall behind the door, the toilet paper holder was missing half of the holder, there were two holes in the wall between where the toilet paper holder mounts, and there was no cartridge to hold the toilet paper. In room 304 the MD discovered the valve for the hot water had been turned off under the sink. The faucet was observed to have been leaking with the hot water valve having been turned off. When the MD turned the hot water valve on, the amount of water leaking from the faucet increased and the MD turned the hot water valve off and stated he

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 584 | Continued From page 20<br>would repair the handles to the faucet so there would not be a leak. The toilet was observed to have had the water turn on approximately every 15 seconds. The MD inspected the tank of the toilet and stated the tank needed a new flapper valve. Three holes were observed in the wall next to the toilet and there was no cartridge in the toilet paper holder to hold the toilet paper. The MD stated he had not received work orders regarding the observations made during the round. The MD stated it was his expectation to receive work orders or be made aware of maintenance matters which required the attention of the maintenance department. The MD stated he had signed the quote for the repair of the hot water holding tank but he was unable to recall when he had signed it. The MD stated the quote had been dated 8/1/18 but he was unable to recall when exactly he had received the quote but stated he had received the quote some time in August. The MD further stated he did not have an exact date of then the hot water holding tank would be repaired.<br><br>An interview was conducted with the Administrator on 9/26/18 at 4:29 PM. The Administrator stated it was her expectation for any employee working at the facility who discovered a matter requiring the attention of the maintenance department to complete a work order or make maintenance aware. | F 584 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's | F 636 | | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 636 | Continued From page 21 | F 636 | | |

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.
(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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 636 | Continued From page 22<br>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.<br>(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.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews, the facility failed to complete comprehensive assessments and Care Areas in a timely manner for 2 of 23 residents (Resident #32 and Resident #53) reviewed for timely completion of assessments and Care Areas.<br><br>The findings included:<br><br>1. Resident #32 was admitted to the facility on 7/3/18 with admission diagnoses which included: Infection, pneumonia, dementia, heart failure, and diabetes.<br><br>Review of Resident #32's most recent Minimum Data Set (MDS)revealed a comprehensive admission assessment with an Assessment Reference Date of 7/10/18. Review of the assessment revealed severe cognitive loss and the resident required supervision and the assistance of one person for all Activities of Daily Living (ADLs). | F 636 | F 636 Comprehensive Assessments and Timing<br>The plan for correcting the specific deficiency<br>The alleged deficiency occurred when the comprehensive assessments and Care Areas were not completed in a timely manner for residents #32 and #55. Resident # 32 Comprehensive assessment was scheduled to be completed by 7/16/18 but was not completed until 7/21/18. Resident # 53 Comprehensive assessment was scheduled to be completed on 5/17/18 and was not completed until 7/21/18. The assessments were accurate and no changes were made to the assessments.<br><br>Procedure for implementing the plan<br>On 10/11/18 the MDS consultant audited current residents to ensure comprehensive assessments have been | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 636 | Continued From page 23<br><br>An interview was conducted with MDS Nurse #1 on 9/26/18 at 4:52 PM. The MDS Nurse stated the Comprehensive Admission Assessment dated 7/10/18 for Resident #32 was not completed in a timely manner. The MDS Nurse stated the assessment should have been completed by or on day 14, 7/16/18, but was not completed until day 19, 7/21/18. The MDS Nurse also stated the Care Area Assessments (CAAs) were not completed until 7/21/18 which were also not completed timely. The MDS Nurse stated the reason the assessment and the CAAs were not completed timely was due to the change in ownership of the facility and the facility and the MDS department was going through a transition. The MDS Nurse stated after the transition was complete there were a lot of assessments which needed to be completed and they had to catch up.<br><br>During an interview conducted with the Administrator on 9/26/18 at 4:29 PM the Administrator stated her expectation was for assessments to be completed and closed timely in accordance with the Resident Assessment Instrument (RAI) Manual.<br><br>2. Resident #53 was admitted to the facility on 5/12/15 with cumulative diagnoses which included: Dementia, depression, and heart disease.<br><br>Review of Resident #53's most recent Minimum Data Set (MDS)revealed a comprehensive annual assessment with an Assessment Reference Date of 5/4/18. Review of the assessment revealed the resident was rarely or never understood indicating severe cognitive loss. The assessment | F 636 | completed as scheduled for the past 30 days. No outstanding late assessments were found.<br>MDS nurses will be re-educated by 10/19/18 by the regional MDS nurse consultant, on timely completion of Comprehensive assessments and Care areas based on the resident assessment instrument (RAI) manual. Any newly hired MDS coordinator will be educated on timely completion of comprehensive assessments and care areas.<br><br>The monitoring procedure<br>The regional MDS nurse consultant will audit all residents that have scheduled comprehensive assessments weekly for 4 weeks and monthly for 2 months to ensure they are completed timely based on the RAI manual. This audit will be documented on a MDS audit tool.<br>The administrator will present the results of the audits to the quality assurance performance improvement committee (QAPI) for recommendations or modifications. The QAPI committee can modify this plan to ensure a facility remains in substantial compliance.<br><br>Title of person responsible for implementing<br>The administrator | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 636 | Continued From page 24<br>was coded having required supervision or assistance of one person for multiple Activities of Daily Living (ADLs) including bed mobility, transfer (such as from the bed to the chair), eating, and toilet use.<br><br>An interview was conducted with MDS Nurse #2 on 9/26/18 at 5:06 PM. The MDS Nurse stated the Comprehensive Admission Assessment dated 5/4/18 for Resident #53 was not completed in a timely manner. The MDS Nurse stated the assessment should have been completed by or on day 14, 5/17/18, and it was not. The MDS Nurse stated the reason the assessment was not completed timely was due to the change in ownership of the facility and the facility. The MDS Nurse stated during the transition process of ownership there was a period of a week when they were unable to access the MDS software on the computer and were working strictly on paper. In addition, the MDS Nurse stated there was a period of about 2-3 months when she was the only MDS Nurse and there were usually 2 MDS nurses. The MDS Nurse stated assessments were not completed timely due to her having been by herself and due to the transition of ownership.<br><br>During an interview conducted with the Administrator on 9/26/18 at 4:29 PM the Administrator stated her expectation was for assessments to be completed and closed timely in accordance with the Resident Assessment Instrument (RAI) Manual. | F 636 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the | F 641 | | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 25<br>resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to accurately code the MDS (Minimum Data Set) for 4 of 23 residents reviewed for accurate MDS coding (Residents # 6, Resident #47, Resident #31 and Resident #116).<br><br>Findings included:<br><br>1. Resident # 6 was readmitted to the facility on 09/27/2011 with diagnoses that included anoxic brain injury, hypertension, and diabetes type 2, pressure ulcer.<br><br>A significant change MDS (Minimum Data Set) dated 06/21/2018 revealed that Resident # 6 was in a persistent vegetative state and was unable to participate in the MDS. Resident # 6 was dependent on at least 2 staff members for bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing. Resident # 6 had an indwelling urinary catheter and was coded as always as incontinent of bowel and had a prognosis that may have resulted in a life expectancy of less than 6 months. Resident #6 was at risk of pressure ulcer development and had one unhealed pressure ulcer that was a stage 4 pressure ulcer that was present on admission and measured 1.8 centimeters (cm) in length by 0.4 cm in width and 0.5 cm in depth. The pressure ulcer had granulation tissue and was present on the prior MDS. Resident # 6 had a pressure relief mattress on the bed, received hydration and nutrition to manage skin problems, received pressure ulcer care, and received a dressing to the pressure ulcer and ointments and or medication to the skin (not on the feet) and | F 641 | F 641 Accuracy of assessments<br><br>The plan for correcting the specific deficiency<br>The alleged deficiency occurred when the minimum data set (MDS) nurse failed to accurately code section M for resident # 6, Section A 1510 for resident # 47, Section A 1500 for resident # 116 and the social worker failed to code section E accurately for resident # 31. Modifications were completed by the social worker and MDS nurse on resident #6, #47, #116, and number #31 by 10/18/18.<br><br>Procedure for implementing the plan<br>Section A1500, A1510, E and M of the most recently completed MDS, for all current residents, will be audited for accuracy by the regional nurse consultant. Modifications if needed will be corrected and submitted by the MDS coordinators. MDS staff, wound care nurse and social workers will be re-educated by the Regional MDS consultant on 10/9/18 regarding the importance of accurately coding the MDS, specifically, section A1500, A1510, section E and M.<br><br>Regional MDS consultant will audit section A1500 and A 1510 by obtaining a list of residents with level 11 PASARR with and without renewal dates and compare to the coding on the MDS. Section E will be audited by comparing the documentation and care planning of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 26<br>Resident # 6 received hospice care.<br><br>A review of the Care Area Assessment (CAA) dated 07/02/2018 for pressure ulcer included that Resident # 6 was dependent for all care and was unable to communicate. Resident # 6 was bed bound, received gastrostomy tube feeding and was incontinent of bowel. Resident # 6 had diabetes type 2 and had a chronic stage 4 pressure ulcer on the coccyx.<br><br>A care plan initiated for Resident # 6 on 12/29/2013 and recently updated on 07/25/2018 revealed that Resident # 6 was at risk for further pressure ulcer development related to a history of pressure ulcers, current breakdown and immobility. On 07/25/2018, Resident # 6 had a stage 4 pressure ulcer to her coccyx that measured 2.3 cm x 0.7 cm x 0.5 cm, had 80% granulation tissue and was healing. Resident # 6 also had shearing of the left elbow, shearing of the left heel and Resident # 6's right heel had drained, and Resident # 6 was on an air mattress. The care plan goal was that Resident # 6's pressure ulcer would show signs of healing and remain free of infection through the next review date. Interventions included to administer treatments as ordered, observe with treatment effectiveness, maintain air mattress to the bed as ordered, assess and record wound status and report to the physician (MD), weekly body check, follow protocol and policy for skin breakdown prevention and treatment. Interventions also included to inform the resident family of skin changes. Provide incontinent care, wedge cushion used for positioning.<br><br>A review of a wound care specialist evaluation dated 06/20/2018 revealed in part that Resident # | F 641 | wandering to the coding on the MDS. Section M will be audited by comparing the wound care notes and nurse practitioner (NP) notes to the coding of the MDS of 5 Minimum data sets per week x 12 weeks to ensure accuracy. After the 12 weeks the regional MDS consult will review section A1500, A1510 , E and M of random completed MDS□s during her visits to ensure the facility maintains compliance.<br><br>Monitoring Procedure<br>Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.<br><br>Person responsible<br>Administrator | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 27 | F 641 | | |

6 had a stage 4 pressure ulcer of the coccyx which had deteriorated because the general condition of Resident # 6. Resident # 6 was observed with a shearing area of the left, lower buttock, a shear wound of the right and elbows and fluid filled blisters caused by shearing of the left and right heels.

On 09/25/2018 at 11:00 AM wound care was observed for Resident # 6 the fluid filled blisters on each heel had resolved and the right heel area was a stage 2 pressure ulcer and the left heel was an unstaged pressure ulcer.

On 09/25/2018 at 2:25 PM an interview conducted with the wound care nurse revealed that she had been doing the wound care for Resident # 6 since she started in the wound care nurse position and that she did not complete the skin condition section (Section M) on the Minimum Data Set (MDS) for any resident and that she gave the MDS nurses a copy of the weekly skin report for their use in the MDS. The wound report provided to the MDS nurses for the MDS dated 06/21/2018 revealed that the heels of Resident # 6 were both fluid filled blisters from shearing. The wound nurse revealed that she did not use the definition of the RAI (Resident Assessment Manual) for wound identification and coding.

An interview was conducted with MDS nurse #2 on 09/25/2018 at 3:16 PM that revealed that she had completed the section M of the MDS for Resident # 6 dated 06/21/2018 and had not coded the fluid filled blisters on the heels of Resident # 6 as stage 2 pressure ulcers. The MDS nurse #2 revealed that she had not reviewed the RAI manual definitions for

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 28 | F 641 | | |

clarification of the coding of the 2 heel blisters that were recorded on the wound report received from the wound care nurse. The MDS nurse # 2 revealed that the heel blisters had been improperly coded on the MDS dated 06/21/2018.

An interview was conducted with the facility administrator on 09/26/2018 at 5:54 PM that revealed that expectation was that all sections of the MDS be completed accurately to reflect the resident condition during the review period. The administrator also revealed that it was expected that the RAI manual be utilized to be certain that all MDS sections be coded correctly.

2.Resident #47 was admitted to the facility on 11/3/2017 with a primary diagnosis of drug induced subacute dyskinesia (involuntary body movement caused by long use of antipsychotic medications) and schizophrenia

A review of an admission Minimum Data Set (MDS) assessment dated 11/20/2017 revealed a blank in Section A1510 Level II PASARR Conditions.

Review of the care plan dated 11/16/2017 focused on antipsychotic medications related to diagnosis of schizophrenia and tardive dyskinesia for Resident #47. Goals for Resident #47 were to remain free of psychotropic drug related complications with intervention that included administration of antipsychotic medications as ordered by physician, observe for side effects and effectiveness every shift, abnormal involuntary movement scale (AIMS) rating every six months,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 29 | F 641 | | |

as needed and monitor/record occurrence of changes in behaviors or moods per facility protocol and notify Team Health Psych for worsening of symptoms.

On 9/26/2018 at 5:45 PM an interview with MDS Nurse #1 revealed she failed to code Resident #47's medical diagnosis of schizophrenia as a Level II PASARR condition under Section A1510. MDS #1 further revealed that the omission was done in error and she planned to submit a modification.

3.Resident #31 was admitted to the facility on 5/13/2015 with diagnoses that included unspecified psychosis, major depressive disorder and anxiety.
A review of a quarterly MDS assessment dated 7/11/2018 revealed in Section E0900 that Resident #31 was coded as no presence of wandering. A review of the Assessment Review Dates (ARD) look back notes for 7/5/2018 - 7/11/2018 revealed Resident #31 wandered on 7/9/2018 and 7/11/2018.

A care plan dated 6/20/2017 focused on elopement risk/wanderer, poor safety awareness and wandering for Resident #31. Goals for Resident #31 were to not leave facility unattended, check placement and function of safety monitoring device as ordered, observe location frequently during care rounds and as needed, document wandering behavior and attempted diversional interventions and reorient and redirect resident as needed.
On 9/25/2018 at 11:22 AM an interview with SW#2 was conducted. SW #2 revealed that she was still learning the MDS coding process and did

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 30 | F 641 | | |

not have a reason for why she did not code Resident #31 for wandering. She further revealed Resident #31 was known to constantly wander the unit.

On 9/25/2018 at 11:54 AM during an interview, SW #1 revealed Resident #31 wandered and she expected Section E0900 to be coded at "1" for wandering behavior occurred 1 to 3 days during the look back period.

On 9/25/2018 at 4:50 PM an interview with MDS Nurse #1, who served as the MDS Coordinator, revealed Section E0900 should have been coded to reflect that Resident #31 wandered 1-3 days.

On 9/25/2018 at 4:58 PM and interview with MDS Nurse #2 revealed she and MDS Nurse #1 should be reviewing the sections for accuracy and completion before submission.

An interview on 9/26/2018 at 6:49 PM with the Administrator revealed she expected the SW to code the MDS correctly and for the MDS nurses to submit accurate and complete MDS's.

3. A review of Resident #116 ' s medical record revealed the Preadmission Screening and Resident Review (PASRR) Level II determination notification dated 1/22/2013 and the document stated as a Level II PASRR, Resident #116 was appropriate for nursing facility placement.

Resident #116 was admitted to the facility on 9/25/2017 with diagnoses to include psychosis,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 31 | F 641 | | |

unspecified intellectual disabilities and hypertension.

A review of the admission Minimum Data Set (MDS) assessment dated 10/2/2017 revealed question A1500 (PASRR) "Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?" The question was scored "1. Yes".

A review of the annual MDS assessment dated 9/6/2018 revealed question A1500 (PASRR) "Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?" The question was scored "0. No".

The Business Office Manager (BOM) was interviewed on 9/26/2018 at 10:15 AM. The BOM reported she requested renewal assessments for residents with Level II PASRR that had an expiration date and Resident #116 was a Level II PASRR, but he did not have an expiration date.

An interview was conducted with MDS Nurse #1 on 9/26/2018 at 10:28 AM and she reported she completed the annual MDS dated 9/6/2018 for Resident #116. MDS Nurse #1 further reported to score question A1500, she reviewed the social work notes, the care plans and the demographics for the resident. MDS Nurse #1 concluded by reporting because there was no PASRR care plan in place, she scored him "0, No" for A1500.

The Social Worker (SW) was interviewed on 9/26/2018 at 2:48 PM. She reported she had not been aware Resident #116 was a PASRR Level II. She further reported a new system would be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 32<br>put in place to track residents with PASRR Level I and PASRR Level II and she would be responsible for submitting residents for PASRR renewal in the future.<br><br>The Director of Nursing (DON) was interviewed on 9/26/2018 at 4:44 PM. The DON explained she was not aware Resident #116 was a Level II PASRR and a new process was initiated to track all residents with Level II PASRR to prevent other residents from being coded incorrectly on the MDS assessment. | F 641 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to implement a care plan for a | F 644 | F 644 Coordination of PASARR and assessments | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 644 | Continued From page 33<br>resident with a Level II Preadmission Screening and Resident Review (PASRR) and failed to incorporate PASRR recommendations into a care plan for 1 of 2 residents reviewed for PASRR care plan (Resident #116).<br><br>Findings included:<br><br>The PASRR Level II determination notification dated 1/22/2013 was reviewed and the document revealed as a Level II PASRR, Resident #116 was appropriate for nursing facility placement.<br><br>Resident #116 was admitted to the facility on 9/25/2017 with diagnoses to include psychosis, unspecified intellectual disabilities and hypertension.<br><br>The care plans for Resident #116 were reviewed and no care plan was in place related to Level II PASRR.<br><br>The Business Office Manager (BOM) was interviewed on 9/26/2018 at 10:15 AM. The BOM reported Resident #116 was a Level II PASRR.<br><br>An interview was conducted with the Minimum Data Set (MDS) Nurse #1 on 9/26/2018 at 10:28 AM and she reported she completed the annual MDS assessment dated 9/6/2018 for Resident #116. MDS Nurse #1 further reported she was not aware Resident #116 was a Level II PASSR because he did not have a care plan in place.<br><br>The Director of Nursing (DON) was interviewed on 9/26/2018 at 4:44 PM. The DON explained she was not aware Resident #116 was a Level II PASRR. The DON further reported a new process was initiated to track all residents with Level II | F 644 | The plan for correcting the specific deficiency<br><br>The alleged deficiency occurred when the social worker failed to implement a care plan to incorporate Preadmission Screening and Resident Review (PASRR) recommendations for resident #116 regarding his level 11 PASRR. Care plan for resident # 116 was updated to reflect the recommendations from PASRR by the social worker.<br><br>Procedure for implementing the plan<br><br>The regional minimum data set (MDS) nurse consultant will re-educate the social workers and Minimum data set nurses, unit managers and Director of nursing, regarding care plans and how to incorporate the level 11 PASRR recommendations and this is to be update according the resident assessment instrument (RAI) manual by 10/24/18<br><br>The interdisciplinary team which is Director of Nursing, unit managers, minimum data sets nurses and social workers will review current residents with a level 11 PASRR to ensure recommendations are in place on the care plan by 10/24/18<br><br>The regional MDS nurse will review care plans on residents with level 11 PASRR weekly x 4 weeks and monthly x 2 months<br><br>Monitoring Procedure | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 644 | Continued From page 34<br>PASRR and to address Level II PASRR residents had appropriate care plans in place. | F 644 | The regional MDS nurse consultant will review residents with level 11 PASRR weekly x 4 weeks and monthly x 2 months<br><br>The MDS coordinator will present the results of the audits to the quality assurance performance improvement committee (QAPI) for recommendations or modifications. The QAPI committee can modify this plan to ensure facility remains in compliance<br><br>Person Responsible for monitoring<br>Director of Nursing<br>Administrator | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or | F 645 | | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 645 | Continued From page 35 | F 645 | | |

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 645 | Continued From page 36<br>disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to submit information for Preadmission Screening and Resident Review (PASARR) for a Level II evaluation for 1 of 3 residents reviewed for PASARR (Resident #47).<br><br>Findings included:<br><br>Resident #47 was admitted to the facility on 11/3/2017 with a primary diagnosis of drug induced subacute dyskinesia (involuntary body movement caused by long use of antipsychotic medications). Resident #47 other diagnoses on admission included toxic encephalopathy, schizophrenia, insomnia and hypertension.<br><br>A review of an admission Minimum Data Set (MDS) dated 11/20/2017 revealed in Section A 1500 that Resident #47 had not been evaluated by Level II PASARR, Section A1510 Level II PASARR Conditions was blank, a brief interview of mental status score (BIMS) of 13 indicated Resident #47 was cognitively intact and Section I5700 was coded for Schizophrenia<br><br>On 9/25/2018 at 4:32 PM an interview with the business office manager (BOM) reveal that she was not aware of which staff member was designated to submit Level II PASARR evaluations at the facility. The BOM disclosed that | F 645 | F 645 PASARR screening for MD & ID<br><br>The plan for correcting the specific deficiency:<br><br>The alleged deficiency occurred when the facility failed to submit information for Preadmission Screening and Resident Review (PASARR) for a level 11 evaluation for resident # 47. Information has been submitted to the North Carolina Medicaid uniform Screening tool (NCMUST) for evaluation.<br><br>Procedure for implementing the plan:<br><br>The interdisciplinary team consisting of the Director of Nursing, Unit managers, Minimum data set coordinators and social worker will review current residents with level 11 PASARR and make referrals to NCMUST as needed by 10/18/18.<br><br>The Administrator will re-educate the social workers by 10/24/18 on requirements for PASARR screening prior to admission and upon receipt of qualifying diagnosis and reviewing the level 11 PASARR with each care plan review and submitting request to NC | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 645 | Continued From page 37<br>she did continuations for Level I PASARRs and checked the PASARR for residents on admission. A copy of the information obtained upon admission for Resident #47 was presented by the BOM. The BOM presented a PASARR Level I screens dated 10/11/2013 and a PASARR Level II Referral Notification dated 10/11/2013. The BOM revealed that she did know how to process PASARR Level II referrals to the North Carolina Medicaid Uniform Screening Program. Additionally, the BOM revealed that Resident #47 was a PASARR Level A at the hospital prior to her admission and she felt that was terminal.<br><br>A follow up interview with the BOM on 9/26/2018 at 10:17 AM revealed that her duties included tracking expiring PASARRs. The BOM further revealed that she only sent FL 2 forms when PASARRs were expiring and did not submit any information for Level II PASARR evaluations.<br><br>On 9/26/2018 at 9:56 AM an interview with SW #1 revealed that she began working in the facility in July 2017 and at that time the business office was responsible for submitting PASARR Level II referrals. SW #1 further revealed that she would assume the responsibility for following up on PASARR Level I and Level II referrals.<br><br>An interview with the administrator on 9/26/18 at 9:46 AM revealed the responsibility of submitting PASARR Level II had not been clearly defined and she expected going forward that all Level II PASARR referrals would be completed by the social worker. | F 645 | MUST as needed.<br><br>New admissions will be reviewed by facility social worker to ensure PASARR is present upon admission, and that the level of PASARR is appropriate for the diagnosis present. Facility social worker will re-submit for a PASARR review as indicated for a change in qualifying diagnosis. The social worker will submit a weekly log that reflect new admissions and any changes or reviews of current PASRR levels.<br><br>The administrator will review the log weekly for eight weeks then monthly for one month.<br><br>Monitoring procedure:<br><br>The Quality assurance and Performance committee (QAPI) will review PASARR logs monthly for 3 months. The QAPI committee can modify this plan to ensure a facility remains in compliance.<br><br>Person responsible for implementing plan:<br><br>Administrator | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4) | F 732 | | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 732 | Continued From page 38<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the | F 732 | F 732 Staff posting | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 732 | Continued From page 39<br>facility failed to correctly report hours worked for licensed staff for 30 out of 30 Posted Staffing Sheets reviewed, failed to correctly report hours worked for unlicensed staff 30 out of 30 Posted Staffing Sheets reviewed, and failed to accurately report the daily census for 30 out of 30 Posted Staffing Sheets reviewed.<br><br>Findings included:<br><br>1. An observation on 9/23/18 at approximately 9:30 AM revealed a Posted Staffing Sheet at the front desk which did not have Registered Nurse (RN) hours posted. In addition, the hours worked by nurses were not categorized into day, evening, and night shift. There was a section for Unit Managers and a section for nurses.<br><br>An observation on 9/26/18 at approximately 8:43 AM revealed a Posted Staffing Sheet at the front desk which did not have Registered Nurse (RN) hours posted. In addition, the hours worked by nurses were not categorized into day, evening, and night shift. There was a section for Unit Managers and a section for nurses.<br><br>An interview was conducted with the Scheduler on 9/26/18 at 8:43 AM. The Scheduler stated she used a spreadsheet for the Posted Staffing Sheet. She stated the staffing sheet did not identify or separate RN hours or if there was an RN for 8 hours at the facility each day. The scheduler stated there were two Unit Managers each weekday and one of the Unit Managers was an RN and the other was an LPN, but the daily posted staffing did not identify if Unit Managers were an RN or a Licensed Practical Nurse (LPN). The Scheduler stated on the weekends there was a Supervisor and she was an RN. The Scheduler | F 732 | The plan for correcting the specific deficiency:<br><br>The alleged deficient practice occurred when the facility failed to correctly report the hours worked for licensed and unlicensed staff and failed to correctly report the census.<br><br>The staffing coordinator was re-educated by the Administrator on 10/22/18 regarding the daily posting of licensed, unlicensed staff and census.<br><br>Procedure for implementing the plan:<br><br>Licensed staff will be re-educated on 10/24/18 by the Director of nursing on checking the daily posting of nurse staffing form, each shift to ensure proper census, licensed and unlicensed hours are correct.<br><br>Daily staffing form from prior day will be reviewed daily by Director of Nursing/ unit coordinators/ scheduler or weekend supervisor to ensure accurate care hours were posted for licensed and unlicensed staff to ensure regulatory compliance.<br><br>Monitoring procedure:<br><br>Copies of the daily nurse staffing posting will be submitted to the Quality Assurance Performance Improvement committee by the staffing coordinator monthly for 3 months, for recommendations or modifications until compliance is achieved. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 732 | Continued From page 40<br>reviewed the Posted Staffing Sheet for 5/19/18. The Scheduler stated there were 9 nurses who had worked on 5/19/18. The scheduler was unable to identify from the Posted Staffing Sheet if the nurses who worked were RNs or LPNs on the date being reviewed. The Scheduler stated she was unable to identify from reviewing the Posted Staffing Sheet how many nurses had worked on day shift, evening shift, and night shift.<br><br>During an interview conducted with the Administrator on 9/26/18 at 4:29 PM the Administrator stated it was her expectation for the Posted Staffing Sheet to be accurate and correctly report licensed staffing, unlicensed staffing, and census.<br><br>2. An observation on 9/23/18 at approximately 9:30 AM revealed a Posted Staffing Sheet at the front desk which did not have the hours worked by Nursing Assistants (NAs) or unlicensed staff categorized into day, evening, and night shift.<br><br>An observation on 9/26/18 at approximately 8:43 AM revealed a Posted Staffing Sheet at the front desk which did not have the hours worked by Nursing Assistants (NAs) or unlicensed staff categorized into day, evening, and night shift.<br><br>An interview was conducted with the Scheduler on 9/26/18 at 8:43 AM. The Scheduler stated she used a spreadsheet for the Posted Staffing Sheet. The Scheduler stated there were 30 NAs who had worked on 5/19/18. The scheduler was unable to identify from the Posted Staffing Sheet how many NAs had worked on day shift, evening shift, and night shift.<br><br>During an interview conducted with the | F 732 | Title of person responsible for implementing the plan:<br><br>Administrator<br>Director of nursing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 732 | Continued From page 41<br>Administrator on 9/26/18 at 4:29 PM the Administrator stated it was her expectation for the Posted Staffing Sheet to be accurate and correctly report licensed staffing, unlicensed staffing, and census.<br><br>3. An observation on 9/23/18 at approximately 9:30 AM revealed a Posted Staffing Sheet at the front desk which had a section titled Today's Census and the number was 130.<br><br>An observation on 9/26/18 at approximately 8:43 AM revealed a Posted Staffing Sheet at the front desk which had a section titled Today's Census and the number was 130.<br><br>An interview was conducted with the Scheduler on 9/26/18 at 8:43 AM. The Scheduler stated she used a spreadsheet for the Posted Staffing Sheet. The Scheduler stated the number in the section titled was always 130. The Scheduler stated the number of 130 was not the correct number for the census on 5/19/18, 9/23/18, or 9/26/18. The Scheduler stated the number of 130 was a fixed number in the spreadsheet and not necessarily representative of the correct census.<br><br>During an interview conducted with the Administrator on 9/26/18 at 4:29 PM the Administrator stated it was her expectation for the Posted Staffing Sheet to be accurate and correctly report licensed staffing, unlicensed staffing, and census. | F 732 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements. | F 812 | | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 812 | Continued From page 42<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews the facility failed to keep the microwave oven and the freezer clean, cover stored ice scoop and failed to label and/or cover refrigerated foods stored in one of three nourishment rooms, the 100 Hall nourishment room.<br><br>Findings included:<br><br>An observation on 9/23/18 at 10:00 am of the 100 Hall nourishment room revealed the ice scoop for the nourishment room's ice maker was lying on top of the ice chest, uncovered.<br><br>Further observation of the 100 Hall nourishment room 9/25/18 at 6:55 am revealed a container of pineapple in a clear plastic container with no label or date and an uncovered and undated plastic container of applesauce were stored in the | F 812 | F 812 Food Procurement, Store/Prepare/Serve-sanitary<br><br>The plan for correcting the specific deficiency:<br><br>The alleged deficiency occurred with the facility failed to keep the microwave clean, the freezer clean, cover stored ice scoop and failed to label and cover refrigerated foods in the 100 hall nourishment room. The microwave and freezer were cleaned immediately on 9/26/18. The ice scoop was cleaned, covered and stored on 9/26/18. Unlabeled and uncovered food was discarded immediately on 9/26/18. Unit managers were re-educated on 9/26/18 by the Director of Nursing on ensuring the nourishment rooms are | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 812 | Continued From page 43<br>refrigerator. A dark brown substance was frozen to the bottom of the freezer, it appeared to be chocolate ice cream. The microwave was noted to have a brown liquid spilled across the bottom. Additionally, the ice scoop was lying on top of the ice maker, uncovered.<br><br>On 9/26/18 at 5:30 pm an observation of the 100 Hall nourishment room revealed two plastic grocery bags of food in refrigerator with no label or dated. The grocery bags contained plastic containers of food with no labels.<br><br>During an interview on 9/26/18 at 6:15 pm the Director of Nursing stated her expectation was the food in the nourishment rooms would be labeled and dated to ensure the safety of the residents. She stated she usually checked the nourishment refrigerators on 6:00 am to 2:00 pm shifts but she planned to start monitoring the nourishment rooms on all shifts for cleanliness and unlabeled and undated food. | F 812 | cleaned daily to include the microwave oven, freezer, covering the ice scoop and discarding all unlabeled food and uncovered food.<br><br>Procedure for implementing the plan:<br><br>The Director of nursing and the Certified dietary manager will re-educate by 10/24/18 licensed, unlicensed nursing staff, dietary staff, housekeeping staff, activity staff and rehabilitation staff on covering food when using the microwave, placing the ice scoop in the cover and labeling any food that is placed in the refrigerator with name and date, discarding any that is not labeled, dated and covered.<br><br>New staff hired for any department after 10/24/18 will receive education on covering food when using the microwave, placing the ice scoop in the cover and labeling any food that is placed in the refrigerator with name and date, discarding any that is not labeled, dated and covered.<br>The dietary aide will visually check all three nourishment rooms and discard any non-labeled or non-dated food in the refrigerators, ensure microwave and freezer are clean and ice scoop is covered daily for 12 weeks.<br><br>Monitoring Procedure:<br><br>The Director of Nursing and Certified Dietary manager will visually inspect all three nourishment rooms 3x a week for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 812 | Continued From page 44 | F 812 | 12 weeks to ensure all food items are covered, labeled and dated, the microwave and freezer are clean and the that the ice scoop is covered and record findings on an audit sheet. After the 12 weeks all three nourishment rooms will be visually inspected daily by the unit manager, supervisor or manager on duty to ensure all food items are covered, labeled and dated, the microwave and freezer are clean and the that the ice scoop is covered.<br>The dietary manager will report the findings of the audits to the quality assurance performance committee (QAPI) monthly x 3 months. At that time, the (QAPI) will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.<br><br>Title of person responsible:<br>Director of Nursing<br>Certified dietary manager | |
| F 814 SS=D | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews the facility failed to dispose of food waste from previously eaten resident meal trays that were stored in 1 of 3 nourishment rooms in the facility. Resident meal trays with plates of opened, uneaten food was observed in facility's 100 Hall nourishment room. | F 814 | F 814 Dispose Garbage and Refuse Properly<br><br>The plan for correcting the deficiency:<br><br>The alleged deficiency occurred when the nursing staff on 100 hall failed to dispose | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 814 | Continued From page 45<br><br>Findings included:<br><br>On 9/25/18 at 6:55 am an observation of the 100 Hall Nourishment Room revealed two resident meal trays with dried food on them sitting on counters, the tray cards revealed the trays were from dinner the on 9/24/18 the prior evening.<br><br>On 9/26/18 at 5:30 pm an observation of the 100 Hall Nourishment Room revealed three resident meal trays which contained dried food from lunch that day.<br><br>An interview on 9/26/18 at 5:36 pm with Nurse Aide #1 revealed the meal trays found in the 100 Hall Nourishment Room on 9/26/18 were from lunch. She stated the previous shift (6:00 am to 2:00 pm) put the trays in the nourishment room. She stated they should have put them on a cart and took them back to the kitchen for disposal.<br><br>An interview on 9/26/18 at 6:15 pm with the Director of Nursing revealed her expectation was the Nourishment Rooms would be kept clean with food trays or any other food left out would be disposed of or sent back to the kitchen for disposal. She stated she usually made round during the 6:00 am to 2:00 pm shift of the Nourishment Rooms and she planned to begin monitoring the nourishment rooms on all shifts. | F 814 | of food waste from previously eaten resident meal trays by taking them to the dietary department for disposal. The nursing staff instead placed the trays in the 100 hall nourishment room.<br><br>Procedure for implementing the plan:<br><br>The Director of nursing and the Certified dietary manager will re-educate by 10/24/18 licensed, unlicensed nursing staff, dietary staff, housekeeping staff, activity staff and rehabilitation staff on proper disposal of resident meal trays after eating.<br>The dietary aide will visually check all three nourishment rooms after meals to ensure that food trays are taken to the dietary department for disposal daily for 12 weeks. After the 12 weeks a dietary aide will continue to monitor the nourishment rooms after each meal to ensure trays are taken to the dietary department after meals. Dietary aide to be educated by Director of Nursing and Certified Dietary Manager.<br><br>Monitoring procedure:<br><br>The Director of Nursing and Certified Dietary manager will visually inspect all three nourishment rooms 3x a week for 12 weeks to ensure dietary trays are not left in the nourishment rooms and record findings on an audit sheet.<br>The dietary manager will report the findings of the audits to the quality assurance performance committee (QAPI) monthly x 3 months. At that time, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 814 | Continued From page 46 | F 814 | the (QAPI) will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.<br><br>Title of person responsible for implementing<br>Director of Nursing<br>Certified dietary manager | |
| F 925 SS=D | Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and staff interviews, the facility failed to promote an insect free environment for 1 of 3 halls reviewed for pest control (300 Hall).<br><br>Findings included:<br><br>Pest control invoices from the pest control service were reviewed for the following dates of 1/31/18, 2/14/18, 3/29/18, 4/16/18, 5/14/18, 6/14/18, 6/25/18, 7/30/18, and 8/13/18. No concerns with the 300 Hall exit door were noted. Further review revealed light activity for houseflies were discovered at the kitchen and at the nurses' station (no specific nurses' station mentioned) on 1/31/18, 2/14/18, 3/29/18, 4/16/18, and 5/14/18.<br><br>Review of the pest control sheet revealed that a new pest company had a service agreement with the facility dated 8/22/18 and it was effective as of | F 925 | F 925 Maintains Effective pest control<br><br>The plan for correcting the specific deficiency<br>• The alleged deficiency occurred because the facility failed to keep the facility free of pest such as spiders, spider webs and dead insects. The housekeeper on 300 hall failed to clean around the 300 hall exit door and remove the spider webs and insects. The 300 hall exit door was cleaned immediately on 9/26/18 upon notification. Housekeeping staff for 300 hall was re-educated on cleaning and dusting and ensuring removal of any dead insects, spider and spider webs and alerting their supervisor if insects are noted.<br><br>Procedure for implementing the plan | 10/24/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 925 | Continued From page 47<br>9/1/18.<br><br>An observation conducted on 9/23/18 at 12:55 PM revealed multiple small dead insects, spider webs, and spider webs in the hall around the exit door for the 300 Hall. The flies, spider webs, and spiders extended on the floor and the ceiling to an insect attractant light.<br><br>An observation conducted on 9/24/18 at 4:06 PM revealed multiple small dead insects, spider webs, and spider webs in the hall around the exit door for the 300 Hall. The flies, spider webs, and spiders extended on the floor and the ceiling to an insect attractant light.<br><br>An observation conducted on 9/25/18 at 3:45 PM revealed multiple small dead insects, spider webs, and spider webs in the hall around the exit door for the 300 Hall. The flies, spider webs, and spiders extended on the floor and the ceiling to an insect attractant light.<br><br>An observation conducted on 9/26/18 at 11:34 AM revealed multiple small dead insects, spider webs, and spider webs in the hall around the exit door for the 300 Hall. The flies, spider webs, and spiders extended on the floor and the ceiling to an insect attractant light.<br><br>An interview was conducted with Housekeeper (HSK) #2 on 9/26/18 at 11:43 AM. The HSK stated she had worked on the 300 Hall and when she had she had discovered roaches in a resident room or bathroom. The HSK stated she had been working at the facility for about a year, Monday through Friday and had not seen an exterminator inside the facility or on the exterior grounds of the facility. | F 925 | • The maintenance director will re-educate on 10/24/18 housekeeping staff, dietary staff, activity staff, rehabilitation staff and licensed and unlicensed nursing staff on pest control and notification if any insects are noted inside the building.<br>• Housekeeping supervisor will visually audit Hallways 3 x a week for 12 weeks, visually audit 10 resident rooms weekly x 12 weeks to ensure they are free of pest and insects.<br>• On (date), Licensed Pest Control company that provides services at the center did a complete pest audit, including full facility treatment inside and outside around perimeter of facility. No other issues related to pest control identified.<br>• Maintenance Director initiated a process for communication by facility employees by creating Maintenance request forms located at each nurse station. Those maintenance request forms will be utilized by facility staff to communicate all maintenance requests and/or any pest noted in the facility that need attention. The Maintenance director will review the maintenance request forms daily (Monday through Friday) and the manger on duty will review request on the weekends and notify maintenance director and address any identified maintenance and/or pest control related issue promptly effective (date). Any negative findings will be documented on the pest control audit forms and maintained in the maintenance log book.<br>• Director of Maintenance, Director of Housekeeping and/or Administrator, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 925 | Continued From page 48<br><br>An interview was conducted in conjunction with an observation with the Maintenance Director (MD) on 9/26/18 at 11:58 AM. The observation revealed multiple small dead insects, spider webs, and spider webs in the hall around the exit door for the 300 Hall. The flies, spider webs, and spiders extended on the floor and the ceiling to an insect attractant light. The MD stated they had changed pest control services from one company to another about a month ago. The MD stated as part of the contract with the new pest control service the company would provide treatment for spiders. The MD stated the former pest control service company came to the facility once per month to treat for pests. The MD stated he would occasionally have reports of bugs or roaches but there were not many complaints.<br><br>An interview was conducted in conjunction with an observation with the Environmental Services Director (ESD) on 9/26/18 at 1:39 PM. The observation revealed multiple small dead insects, spider webs, and spider webs in the hall around the exit door for the 300 Hall. The flies, spider webs, and spiders extended on the floor and the ceiling to an insect attractant light. The MD stated they had changed pest control services from one company to another about a month ago. The ESD stated he had had a floor technician come back and had cleaned some of the spider webs and dead insects. During the observation 3 spiders were observed to have been crawling on the spider webs with dead insects which had remained. The ESD stated it was his expectation was for the housekeeping staff to clean and dust general areas such as the halls weekly and there should not have been a buildup of spider webs, spiders, and insects inside of the facility. | F 925 | Director of Nursing (DON), and/or Staff Development Coordinator (SDC) will complete re-education for all current facility employees, to include full time, part time and as needed employees on reporting any noted pests in the facility promptly on a Maintenance request form located each nurse station. The emphasis of this education was on the importance of communicating any noted pest in the facility. This education will be completed by 10/24/18, this education will also be added on new hire orientation.<br><br>Monitoring process<br>• Effective 10/22/18, Administrator, and/or Director of Nursing will monitor compliance by reviewing maintenance log and Pest Control book to ensure compliance on both usage by facility staff and to ensure that the Maintenance Director review the books daily (Monday through Friday). This monitoring process will take place weekly for four weeks, then monthly for two more months. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a pest Control Review form and submitted to the Quality assurance performance committee (QAPI) for any additional monitoring or modification of this plan monthly for three months. The QAPI committee will modify this plan to ensure the facility maintains substantial compliance.<br><br>Title of person responsible<br>Maintenance director | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 09/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ACCORDIUS HEALTH AT SALISBURY | 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 |

| (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 925 | Continued From page 49<br><br>An interview was conducted with the Administrator on 9/26/18 at 4:29 PM. The Administrator stated it was her expectation have high dusting and cleaning completed and if there was an insect problem to communicate the problem to the pest control services company to address the problem. In addition, the Administrator stated if there was a gap where the door did not close flush the maintenance department would address the problem, so the door would have a tight seal when closed. | F 925 | Administrator | |