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	345081	A. BUILDING _____ B. WING _____	C 01/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation and follow up to a complaint investigation was conducted from 1/16/20 to 1/18/20. Three of the twelve allegations were substantiated.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. 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. §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. §483.10(a)(2) The facility must provide equal 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. §483.10(b) Exercise of Rights. 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. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		2/10/20

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

Electronically Signed | 02/07/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to treat a resident with dignity and respect by entering the resident's room without knocking or asking permission to enter for 1 of 3 resident reviewed for dignity. (Resident #1) Findings included: Resident #1 was admitted to the facility on 2/08/2018 with diagnoses which included coronary artery disease and heart failure. Resident #1's quarterly Minimum Data Set (MDS) dated 11/06/2019 revealed resident was cognitively intact. The MDS indicated Resident #1 required extensive assistance for activities of daily living including bed mobility, transfer, toilet use, personal hygiene and eating. An observation and interview were conducted with Resident #1 on 1/16/2020 at 10:58 AM. During the interview, the resident was in bed, and the door to the resident's room was closed. At 11:09 AM Housekeeping staff #2 was observed entering the resident's room and she walked in to the bathroom and exited the room. Housekeeping #2 did not knock on the resident's	F 550	F550 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. •Housekeeper #2 was re-trained by Director of Nursing on 1/16/20, which included the intent of F550, emphasizing the resident's right to be treated with dignity and respect which includes knocking, asking permission, speaking to the resident and awaiting response from resident. •An apology was provided to Resident #1 by the housekeeper #2 for entering her room without knocking or receiving permission immediately after being re-trained on the content of F550 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; •Current residents were interviewed to ensure that their resident rights are being adhered to in accordance to F550 and its content. Interviews were conducted by	

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F 550	Continued From page 2 door or ask permission to enter the resident's room and did not speak to the resident. When Housekeeping staff #2 entered the room without knocking, the resident stated she was startled, felt scared and thought someone was coming in to hurt her or one of the other ladies in her room. The resident also indicated staff entered her room very often without knocking. An interview was conducted with housekeeping staff #2 on 1/16/2020 at 11:30 AM. Housekeeping staff #2 reported she was aware staff needed to knock and announce prior to entering all resident rooms. Housekeeping staff # 2 stated she was in a hurry, had been in Resident #1's room earlier in the morning, and forgot to check the trash can located in Resident #1's bathroom. An interview was conducted with the Environmental Services Manager on 1/16/2020 at 11:36 AM. She stated all housekeeping staff were aware of the importance of knocking on a resident's room door prior to entering a resident's room. She also stated she began re-education on 1/16/2020 for environmental staff on the required action of knocking on all resident's doors before entering rooms. An interview was conducted with the Director of Nursing on 1/16/2020 at 11:45 am. She stated all staff were required to knock before entering a resident's room.	F 550	members of the Interdisciplinary team (includes Social Worker, Activities Director, Director of Nursing, Administrator, Maintenance Department, Business Office Manager, Nursing Managers, and MDS). Interviews were concluded on 1/31/2020. Residents who were unable to be interviewed the resident representative was contacted to ensure the resident rights were being honored by staff. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; •Observation rounds are completed dally M – F by the facility QAPI Team (includes SW, AD, DON, Administrator, MD, BOM, Nurse Managers, and MDS), and weekends by the Manager on Duty, during these rounds staff interaction is observed to ensure staff is knocking or requesting permission prior to entering resident rooms. Random resident interviews are conducted by the facility QAPI Team during their observation rounds to ensure that any concerns from residents can be identified. If concerns are noted, they are recorded on the resident grievance form and discussed daily M-F at the facility AM Meeting. The facility Administrator will ensure that any grievance is addressed timely and written response reviewed with resident or responsible party. •For residents not able to voice concerns	

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F 550	Continued From page 3	F 550	interviews with resident families will be completed by the facility QAPI Team. •All staff will be re-trained on F 550 and its content including the importance of knocking or asking permission before entering a resident's room. Any staff not re-trained on or by 1/31/2020 will be educated prior to their next working shift. New employees will receive training on F550 during their orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; •10 residents will be interviewed at random weekly X4, monthly X3, and quarterly thereafter by a member of the IDT or designee to ensure that staff is adhering to resident's rights in accordance with F550. Any concerns will be brought to the attention of the Administrator, to be addressed as a facility grievance. Findings will be document on Resident Right Audit tool. •A Summary of monitoring efforts will be completed by Executive Director and presented at the facility monthly QA Meeting for review by the committee members to ensure continued compliance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		2/10/20

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F 690	Continued From page 4 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure an indwelling urinary catheter was stabilized to a resident ' s leg with a leg strap for 1 of 3 resident reviewed for urinary catheter use. (Resident #7)	F 690	F690 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 690	Continued From page 5 Findings included: Resident #7 was admitted to the facility on 3/28/2019 with diagnoses which included hypertension, orthostatic hypertension, renal insufficiency and obstructive uropathy. Resident #7 ' s quarterly Minimum Data Set (MDS) dated 11/11/2019 revealed resident had moderate cognitive impairment. The MDS indicated Resident #7 required extensive assistance for activities of daily living including bed mobility, transfer, dressing, toilet use, and personal hygiene. The care plan for Resident #7, last reviewed by staff on 12/18/2019, included an indwelling catheter and an intervention to secure the catheter with a locking device to prevent tension on the urinary meatus from the catheter. An observation of catheter care on 1/16/2020 at 12:10 PM revealed Resident #7 was lying in bed with the urinary catheter bag on the left side of the bed. The catheter drainage tube was lying across the left leg with no leg strap or secure locking device. During an interview with Nursing Assistant #3 (NA #3), on 1/16/2020 at 12:12 PM, revealed he was responsible for Resident #7 ' s care during the 7:00 AM to 3:00 PM shift. NA #3 stated Resident #7 should have on a leg strap for stabilization of the indwelling catheter and drainage tubing. He also stated he was not sure why Resident #7 did not have on a leg strap. He further stated he would attempt to get a leg strap for Resident #7 after he finished with Resident #7 ' s catheter	F 690	practice. •A leg strap was provided to resident #7 to ensure stabilization during catheter care by attending cna immediately after performing care •A 1:1 inservice was provided to CNA involved with resident at the time of this occurrence on F690, emphasizing the importance of ensuring that a resident's catheter care includes providing a leg strap for support. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; •Director of Nursing Services and/or Nurse managers completed an observation audit on 1/28/2020 of current residents with a catheters to ensure they had a leg straps to ensure support. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; •Catheter Audit tool has been implemented to ensure that all resident catheters consist of leg strap prior staff providing catheter care. Audit is being completed by a nurse manager or designee 5 days a week. •Current nursing staff have received re-training on the content of F690 by the Director of Nursing and/or nursing	

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F 690	Continued From page 6 care. An interview was conducted with the Director of Nursing on 1/16/2020 at 12:27 PM. She stated Resident #7 should have on a leg strap for the indwelling urinary catheter.	F 690	managers, emphasizing the importance of ensuring that a resident's catheter care includes providing a leg strap for support. Any staff not re-trained on or by 1/31/2020 will be educated prior to their next working shift. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; •All residents with catheters will be observed daily by nursing managers or designee at the start of each shift to ensure that all leg straps are in place prior to care being provided. Monitoring will occur 5 days a week X3, 3 days a week X2, Weekly X1 and quarterly thereafter to ensure adequate compliance with F690. •A Summary of monitoring efforts will be completed by Director of Nursing and presented at the facility monthly QA Meeting for review by the committee members to ensure continued compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		2/10/20

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F 880	Continued From page 7	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 8 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to dispose of soiled linen and soiled incontinence briefs in a manner that would prevent the spread of infection during observations of two staff members on two different shifts. Findings included: The facility did not have a specific written policy on the placement and transportation of contaminated laundry or soiled incontinence refuse in bags or containers. 1.An observation was made on 2/17/20 at 3:38 PM of Nurse Aide (NA #1) exiting a room with two clear plastic bags, one containing soiled linen and one containing soiled incontinence refuse. NA #1 placed the two plastic bags on the floor next to the doorway outside of room 23 and entered the room. Nurse #1 picked up the two plastic bags off the floor and took them to the soiled linen closet as NA #1 looked through the closet in room 23.	F 880	F880 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. •Nurse aide #1 and Nurse aide #2 were both educated by the Director of Nursing on 1/16/2020 on the content of F880, emphasizing the importance of handling soiled and contaminated linen / trash in a manner that prevents the surface contamination and transmission of communicable diseases and infections. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; •Current nursing staff were educated by	

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F 880	Continued From page 9 NA #1 was interviewed on 2/18/20 at 10:02 AM. NA #1 revealed she had been working at the facility for 5 days. NA #1 indicated she had training at the facility during which she observed and worked with other nurse aides to learn the facility policies on the disposal of soiled linen and personal resident refuse. NA #1 revealed one of the nurse aides she worked with had placed the bags of used linen and personal refuse at the doorways of the resident rooms and then collected the bags later, taking them to the dirty soiled linen closet. NA #1 stated the other nurse aide she had training with took the linen and refuse bags to the soiled linen closet after providing care in each room. The Director of Nursing (DON) was interviewed on 2/18/20 at 2:42 PM. The DON lamented that NA #1 was a new nurse aide who needed training on the proper disposal of soiled linen and soiled personal refuse. The DON stated that if she had observed the nurse aide putting dirty linen/refuse bags on the floor, she would have corrected the nurse aide immediately to dispose of the soiled linen and refuse bags in the soiled linen closet after care was provided. 2. An observation was made on 1/18/20 at 5:43 AM. Clear plastic bags with dirty incontinence briefs and linens were observed on the floor outside of room 8. NA #2 came out of room 8, put linen back on the linen cart, picked up the bags of dirty incontinence briefs and linens from the floor outside room 8, and then took the bags to the soiled linen closet. NA #2 was interviewed on 1/18/20 at 10:17 AM. NA # 2 indicated she had been working at the	F 880	the Director of Nursing on the intent of F880, emphasizing the importance of handling soiled/contaminated linen/trash in a manner to prevent (presents) surface contamination and/or(the development & transmission of communicable diseases and infections. Anyone not receiving this education as of 2/10/20, will not be allowed to work until they have received this training. New employees will receive this training during their orientation. This training will be completed by 2/10/20 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; •The policy on handling soiled linen and laundry has been revised to reflect CDC and SPICE recommendations, by the VP of Clinical Services on 2/5/20. •Facility Ambassador Round sheets have been modified by administrator on 1/31/2020 to include whether or not proper handling of laundry/linen was observed. •Current nursing staff will be in-serviced on intent of F880 and its content as well as trained on the new policy emphasizing the importance of handling soiled/contaminated linen/trash in a manner to (presents the development) prevent surface contamination and/or transmission of communicable diseases and infections. Anyone not receiving this education as of 2/10 will not be allowed to	

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F 880	Continued From page 10 facility for about a year and that she usually worked on the 11:00 PM to 7:00 AM shift. NA #2 was asked what the proper procedure was for disposing of dirty linen and dirty incontinence briefs. NA #2 maintained that she would never put dirty linen or dirty incontinence briefs on the floor without putting them in bags. NA #2 revealed that proper procedure was to put the dirty linen and used incontinence briefs in plastic bags, carry them to the soiled linen closet, and place them in bins after care was provided for a resident. NA #2 reiterated that she had not put the dirty linen and the soiled linen directly on the floor but had put them in tied plastic bags. The Director of Nursing (DON) was interviewed on 2/18/20 at 2:42 PM. The DON insinuated that NA #2 should have known better then to put the bags of dirty linen and soiled incontinence briefs on the floor outside the room and that she had picked up a bad habit. The DON indicated NA #2 had the mistaken idea that it was okay to put the dirty linen and personal refuse on the floor if they were in a plastic bag but would be retrained to gain further understanding.	F 880	work until they have received this training. New employees will receive this training during their orientation. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; •Daily Round sheets will be submitted to Facility administrator during AM Team Meetings, 5 days a week X3 weeks, 3 days a week X2, and weekly going forward. •A Summary of monitoring efforts will be completed by Facility Administrator and presented at the facility monthly QA Meeting for review by the committee members to ensure continued compliance.	