STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AND REHABILITATION	38 CARTERS ROAD GATESVILLE, NC 27938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 01/26/2020 through 01/30/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #G5MS11. .	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 2 of 22 residents whose MDS Assessments were reviewed (Resident #54 and #56). The findings included: 1. Resident #54 was admitted to the facility on 1/10/20 and had a diagnosis of paranoid schizophrenia and bi-polar disorder. Review of the Admission Minimum Data Set (MDS) Assessment dated 1/17/20 revealed the resident had moderate cognitive impairment. According to the MDS the resident was not a level 2 for Pre-admission Screening and Resident Review (PASRR). Review of the Pre-admission Screening and Resident Review form for Resident #54 revealed the resident was a level 2 PASRR. On 1/29/20 at 9:56 AM the Social Worker stated in an interview that Resident #54 was a level 2	F 641	F641 □ Accuracy of Assessments Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. The admission comprehensive assessment for Resident #54 has been modified on 1/29/2020 to reflect Level 2 PASRR. The modification was transmitted on 1/29/2020. The Social Worker has been in-serviced and re-educated by the Administrator on 1/29/2020 on importance of accuracy of her comprehensive assessments on Section A. Failure to complete accurate assessments related to PASRR by the Social Worker will result in further re-education and also may result in disciplinary action up to and including termination of employment through the facility progressive disciplinary policy. The MDS for resident #56 was modified to include hospice services on 1/30/2020	2/14/20

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

Electronically Signed | 02/16/2020

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F 641	Continued From page 1 PASRR and the screening was done while the resident was in the hospital prior to admission to the facility. On 1/30/20 at 11:23 AM the Social Worker stated in an interview that she was responsible for coding the PASRR on the MDS and she had this resident on her list of PASRR level 2 residents but she must have clicked on the wrong information on the MDS. An interview was conducted with the Director of Nursing and the Administrator on 1/30/20 at 4:30 PM. The Administrator stated the social worker was usually very proficient with PASRRs and it sounded like a human error in coding the MDS. The Administrator stated she had already started to re-educate the social worker and had started on a performance improvement plan regarding the issue. 2. Resident #56 was admitted to the facility on 2/1/2018 with diagnoses to include acquired absence of the right and left leg above the knee, gastroesophageal reflux disease, hypertension, diabetes mellitus and peripheral vascular disease. A review of the physician's orders dated 3/5/2019 revealed an order for Hospice care services. The Significant Change Minimum Data Set (MDS) Assessment dated 3/14/19 for Resident #56 did not include Hospice services. A review of the most recent Minimum Data Set (MDS) Assessment dated 12/14/2019 revealed that Resident #56 was alert, had severe cognitive	F 641	and the modification was transmitted. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: b. Section A of the most recently completed MDS as of 1/29/2020 for all current residents, will be audited for accuracy by the regional nurse consultant. Modifications if needed will be corrected and submitted by the Social Worker. There are currently no other residents in the facility that are receiving hospice. Any new order for hospice will result in a significant change in status MDS capturing hospice and all new admissions with orders for hospice will have this captured on the MDS. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: c. Social Worker was re-educated by the Regional MDS consultant on 1/29/2020 regarding the importance of accurately coding the MDS, specifically, section A. Regional MDS consultant will audit section A of 5 Minimum data sets per week x 12 weeks to ensure accuracy. After the 12 weeks the regional MDS consult will review section I of random completed MDS□s during visits to ensure the facility maintains compliance Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 641	Continued From page 2 impairment and had adequate vision and hearing. The MDS noted the resident was totally dependent upon staff for all activities of daily living (ADLs). According to the MDS the resident had a life expectancy of less than 6 months but was not coded for Hospice. An interview with Nursing Assistant (NA) #1 on 1/28/2020 at 2:45 PM revealed that Resident #56 was total care for ADLS and had been on Hospice for quite some time. An interview with Nurse #2 on 1/28/2020 at 2:48 PM revealed that Resident #56 was receiving Hospice services for more than 30 days. An interview was conducted with the MDS Coordinator on 1/30/2020 at 3:30 PM. The MDS Coordinator stated that Resident #56 was on Hospice services. She further stated that she had made a mistake and missed coding the resident as being on Hospice services on the resident's 3/14/19 and 12/14/19 MDS assessments. An interview with the Director of Nursing (DON) on 1/30/2020 at 3:35 PM revealed that the process was for the MDS to be coded accurately to reflect the resident's status.	F 641	e.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by Social Worker 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.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		2/14/20

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F 761	Continued From page 3 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to securely store medications on a medication cart for 1 of 2 medication carts that were observed. Findings included: Review of the facility Medication Administration Competency check off form revealed #10 read, "Medication carts are to be locked when out of sight of a licensed nurse." On 01/28/20 at 9:45 AM an observation was made of an unattended medication cart parked on the D Hall, unlocked, with the keys to the cart dangling in the keyhole of the narcotic drawer. At 9:50 AM Nurse #1 returned to the cart. In an interview at that time she stated she did not have to lock her medication cart if she had the cart	F 761	F761 – Label/Store Drugs and Biologicals Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. On 1/28/2020 Nurse #1 was re-educated by Director of Nursing on the label/storage of drugs and biologicals policy and the medication administration policy Address how the facility will identify other residents having the potential to be affected by the same deficient practice: b. On 1/28/2020 Director of Nursing began a daily audit of medication carts to ensure they are locked when out of sight of a licensed nurse, and to correct any	

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F 761	Continued From page 4 parked in front of the room where she was administering medication and the cart was in her line of vision. She acknowledged she had taken her eyes off the cart to attend to the resident but insisted she did not have to lock the cart if it was parked in front of the room. She removed the medication keys that were dangling from the narcotic drawer and placed them in her pocket. An interview was conducted with the Director of Nursing on 01/28/20 at 10:05 AM. She stated that whenever a nurse walked away from a medication cart it was to be locked. She commented staff were educated in orientation to keep medication carts locked when unattended and to keep the keys to the cart on his or her person. An in-service titled, "Removing keys from cart/Med Admin", was conducted on 1/28/20 by Nurse #2. In an interview conducted on 1/29/20 at 4:30 PM with Nurse #2 she stated she educated the staff nurses to lock the medication cart if they walked away from it, to lock the computer screen and to remove the keys from the cart. She said it was not acceptable to leave the keys to a medication cart dangling in the keyhole on the front of the cart or to leave an unlocked medication cart unattended.	F 761	deficient practice Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: c. Re-education by Staff Development Coordinator was provided to current licensed nurses on the label/store of drugs and biologicals and medication administration policy. This education will be added to new employee orientation Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: d. Data obtained during the audit process will be analyzed for patterns and trends and reported toe the Quality Assurance and Performance Improvement Committee by the Director of Nursing 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	