STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 COVID-19 Focused Survey was conducted on 8/20/2020. A surveyor returned to the facility on 8/24/20 and 8/27/20 to obtain additional information. The survey exit date was 8/27/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# IYVP11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 8/20/2020 through 8/27/2020. The survey team entered the facility on 8/20/2020 and exited on 8/20/2020. A surveyor returned to the facility on 8/24/2020 to obtain additional information and additional information was obtained off site through 8/27/20. Therefore, the exit date is 8/27/20. There were a total of 7 complaint allegations investigated 3 of the allegations were substantiated as a result of the survey. Event ID #IYVP11. Substandard Quality of Care was identified at: CFR 483.12 at F 600 at a scope and severity H. A partial extended survey was also conducted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		9/16/20

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

Electronically Signed | 09/21/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1	F 580		

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, nursing staff interviews and medical providers interviews, the facility failed to notify the resident's responsible party and the facility's medical providers regarding an opened wound on a resident's foot for 1 of 3 residents reviewed for notification of significant changes (Resident #1). Resident #1 was readmitted to the facility on 2/10/20 with medical diagnoses inclusive of type two diabetes mellitus, hypertension, and peripheral vascular disease. Resident #1 transferred to the hospital on 8/12/2020 and was discharged from the facility. Resident #1's last quarterly Minimum Data Set (MDS) dated 8/3/2020 revealed that she was severely cognitively impaired. She was dependent on one person providing activities of daily, specifically personal hygiene. The MDS also identified Resident #1 was 2 persons assist with bed mobility and transfers. The MDS indicated she was at risk for pressure ulcers but had none at the time of the assessment. The MDS identified Resident #1's weight to be 72 pounds. Resident #1's care plan updated 8/3/2020 included focus areas for activities of daily living (ADL) self-care performance deficit, behavior problem related to refusing ADL care, at risk for further pressure ulcer development, and resident has wound infection of right lateral foot (initiated 8/11/20) with a goal that resident will be free of infection and interventions to administer antibiotics as ordered by provider. .	F 580	Resident affected: 1) Resident was discharged to the hospital. 2) Director of Nursing suspended this Nurse pending investigation on 8/28/2020, and later disciplined with a Final Warning and demoted from her position as Unit Manager due to the severity of the deficiency noted. 3) This nurse was re-educated on the policy and procedure of Change in a Resident□s Condition or Status also on the Quick View Policy on Skin and Change in Condition, by Director of Nursing on 9/14/2020 Residents with potential to be affected: 1) All residents have the potential to be affected by the deficient practice. An audit was conducted on 8/28/2020 for the past 30 days on incident reports to confirm that new wounds had treatments in place and notification to medical director and responsible party were completed. 2) All Staff will be re-educated on the above Quick View (Skin and Change in Condition), as well as the notification policy of any Change in Condition, and utilization of Risk Management, by the Staff Development Coordinator and completed on 8/28/2020. Systemic Changes: Clinical IDT Meeting will meet daily x 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 A record review of Resident#1 progress notes included Nurse #3's documentation dated 7/28/2020 and timed 5:05 PM. The note indicated a nurse aide informed this writer of new open area to Resident's (Resident #1) right inner foot. Area cleaned and dressed. Wound care nurse and hall nurse notified. An interview was conducted on 8/24/2020 at 2:52 PM with NA #4. She stated while assisting Resident #1 with a shower on 7/28/2020, she observed a small sore on the side of her right foot. NA #4 stated she informed the floor nurse assigned to Resident #1 and Nurse #3 on the same day. She was not able to identify who the assigned floor nurse was at the time of the interview. NA #4 reported she observed a dressing on Resident #1's right foot on the following day. On 8/24/2020 at 2:41 PM, an interview was conducted with Nurse #3. Nurse #3 reported that she was notified by NA #4 that Resident #1 had an open skin area on her right foot on 7/28/20. During the interview, Nurse #3 described the open skin area by stating the area looked like a blister that had ruptured at some point, no redness or swelling, no skin flap from possible rupture. She also stated she did not notify Resident #1's responsible party, or a facility provider of her observation or receive treatment orders from a provider. Nurse #3 reported she wrote a note on a piece of paper informing Nurse #2 of her observation of Resident #1's skin/open wound on her right foot and what she did to dress the wound. Nurse #3 stated she left the piece of paper in Nurse #2's box for her to review on the next day. Nurse #3 stated she thought she also	F 580	and have Weekend Supervisor complete the Clinical Meeting form on weekends to maintain continuity of care and communication on an ongoing daily basis. Each day the IDT/Supervisor will review the Dashboard to acknowledge any admissions or discharges and ensure orders in place as well as Admission Skin Assessment completed in timely fashion, Review Risk Management for any new incidents to ensure notification and Interventions are in place. Copy and Review the orders from the previous day to ensure completion, copy and review the progress notes from the previous day to ensure all processes are in place and identify any changes in condition and ensure notification to physician. During Morning Clinical Meeting IDT will review Risk Management and Daily Progress notes to ensure that all issues have been addressed per facility processes of review, documentation, treatment and notification of change. Notification to RP and MD will be confirmed. Staff Development Coordinator will include Change in Condition policy education in the new hire orientation process. Completion date for this plan of correction is 9/16/2020. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 had informed Nurse #2 verbally of her observation and how she had dressed the open wound of Resident #1 on the day following 7/28/2020 She also stated NA #4 informed her that she had informed the floor nurse. Nurse #3 stated she expected the floor nurse (whom she was unable to identify) to have informed Resident #1's responsible party and the facility's medical provider. Nurse #3 acknowledged she should have confirmed the facility's medical provider had been informed or she should have informed the facility's medical provider of her observation and care provided for Resident #1's open wound. On 8/24/2020 at 5:30PM during a phone interview with Nurse #5, he recalled completing the skin review for Resident #1 early in the day shift (7:00AM - 3:00PM) on 7/28/20. Nurse #5 stated he performed a head to toe skin assessment with assigned residents when completing a weekly skin review. He stated he did not identify concerns or observe skin breakdown or any open areas on Resident #1's right foot. Nurse #5 was not able to recall if he had been informed by a nurse aide or Nurse #3 that Resident #1 had an open wound on her right foot on 07/28/20. An interview was conducted on with the facility's wound nurse, Nurse #2, on 8/24/2020 at 2:30PM. During the interview with Nurse #2, she reported having no knowledge of, nor had received written or verbal communication any skin breakdown for Resident #1 prior to her observation on 8/10/2020. An interview with the Director of Nursing (DON) was conducted on 8/24/2020 at 3:45PM. The DON stated her expectation was for all nurses to complete a risk management assessment and	F 580	monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the QA Committee and will review the audits and ensure compliance is ongoing and determine a need for further audits/in-services. Director of Nursing and/or Staff Development Coordinator will monitor this process five times a week for two weeks, then three times a week for two weeks, and then weekly for four weeks. This Plan of Correction was presented to the QAPI / IDT Team on 9/16/2020 and will be monitored monthly for 3 months for review and guidance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 notify the facility's medical providers of observations of changes in skin condition. The DON also stated Nurse #3 should have completed the risk management assessment on 7/28/2020 and notified Resident #1's responsible party and the facility's medical provider of Resident #1's new area of skin breakdown observed on 7/28/20. An interview with the facility's Nurse Practitioner on 8/25/2020 at 3:41 PM, NP #1 stated she expected to be notified of any new open skin areas observed by nursing staff. NP #1 stated she would have expected Nurse #3 to have contacted a facility provider on 7/28/20 regarding Resident #1's new open skin area on her right foot. On 8/25/2020 at 3:48PM, during an interview with the facility's medical director, he stated facility nurses should call to inform the facility providers of new open skin areas. He would have expected Nurse #3 to contact a facility provider on 7/28/20 regarding Resident #1's new open skin area on her right foot.	F 580		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 6 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, nursing staff interviews and medical providers interviews, the facility neglected to communicate. accurately track, document, assess and initiate medical treatment for an opened wound on a resident's foot for 1 of 3 residents who was at high risk for wound development and experienced a significant change in wound condition. The resident was transferred to the hospital and was observed with a necrotic open foul-smelling wound on her lateral right foot with tendons exposed on her right fifth toe (Resident #1). The findings included: Resident #1 was readmitted to the facility on 2/10/20 with diagnoses which included; dementia, adult failure to thrive with severe protein/calorie malnutrition, type two diabetes mellitus, previous left below the knee amputation, chronic kidney disease stage 3, coronary artery disease with previous stent placement, remote history of stroke, and peripheral vascular disease. A weekly skin review/assessment was completed by Nurse #5 on 7/28/20 and indicated Resident #1's skin was intact. On 8/24/2020 at 5:30PM during a phone interview with Nurse # 5 stated he performed a head to toe skin assessment with assigned residents when completing a weekly skin review. On 7/28/2020,	F 600	Resident affected: Resident number #1 was sent to the hospital for evaluation and treatment. Nurse #4 was suspending pending investigation. Nurse #4 was re-educated on the facility abuse and neglect policy on 9/14/2020 by Director of Nursing. Residents with potential to be affected: All residents are at risk for deficient practice; therefore, a 100% resident audit was conducted by the Director of Nursing, Staff Development Coordinator and Wound Care Nurse to identify any new wound areas. If any were identified, an incident report was completed, and the physician, responsible party and resident were notified. No new areas were identified. This audit was completed on 8/28/2020 3) In-service ALL STAFF Abuse & Neglect at 100% by Staff Development Coordinator on 8/28/2020 4) In-Service the Clinical Staff to complete Shower sheets daily and/or report refusals in order to document, initiated by Staff Development Coordinator on 9/14/2020. 5) Initiated a Communication Log for staff to inform Wound Nurse of any new skin issues or orders pertaining to any new skin issues on 8/24/2020. Staff educated on new Communication Log by Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 7	F 600		

he recalled completing the skin review for Resident #1 early in the day shift (7:00AM - 3:00PM). He stated that he did not identify concerns or observe skin breakdown or any open areas on Resident #1's right foot. Nurse #5 was not able to recall if he had been informed by a nurse aide that Resident #1 had an open wound on her right foot on 07/28/20.

A progress note for Resident #1 written by Nurse #3 on 7/28/2020 and timed at 5:05 PM specified a nursing assistant (NA) informed Nurse #3, unit manager, of a new open area to the resident's right inner foot. The note also specified the area was cleaned and dressed and the wound care nurse and hall nurse were notified.

An interview was conducted on 8/24/2020 at 2:52 PM with NA #4. She stated while assisting Resident #1 with a shower on 7/28/2020, she observed a small sore on the side of her right foot. NA #4 stated she informed the floor nurse assigned to Resident #1 and Nurse #3 on the same day. She was not able to identify who the assigned floor nurse was at the time of the interview. NA #4 reported she observed a dressing on Resident #1's right foot on the following day. NA #4 stated after 7/29/2020 she did not observe any skin changes or dressings on Resident #1's right foot.

On 8/24/2020 at 2:41 PM, an interview was conducted with Nurse #3. Nurse #3 reported that she was notified by NA #4 that Resident #1 had an open skin area on her right foot on 7/28/20. During the interview, Nurse #3 described the open skin area by stating the area looked like a blister that had ruptured at some point, no redness or swelling, no skin flap from possible

Development Coordinator on 8/24/2020.
6) Wound Nurse will educate all nursing staff by 9/18/2020 on preventative measures available to provide preventative skin breakdown

Systemic Changes:
Clinical IDT Meeting will meet daily x 5 and have Weekend Supervisor complete the Clinical Meeting form on weekends to maintain continuity of care and communication on an ongoing daily basis. Each day the IDT/Supervisor will review the Dashboard and 24 hour report to acknowledge any admissions or discharges and ensure orders in place, as well as Admission Skin Assessment completed in timely fashion, Review Risk Management for any new incidents to ensure notification and Interventions are in place, and ensure shower sheets are completed. Copy and Review the orders from the previous day to ensure completion, copy and review the progress notes from the previous day to ensure all processes are in place and identify any changes in condition and ensure notification to physician, responsible party and resident, and ensure treatment is in place.

The Clinical Morning Meeting IDT will continue to meet daily x 5 and have the Weekend Supervisor on the Weekend to ensure the Clinical Processes are being followed. That would include 24 hour log, Admission/Readmission, Skin Assessments, Weekly Skin assessments, Shower Sheets, Risk Management, New

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 8 rupture. She also stated the open skin area was red and beefy with clear drainage, maybe quarter sized. Nurse #3 reported she cleaned the open wound with an enzymatic debriding ointment, a sterile non-adhesive protective dressing and a gauze bandage roll. Nurse #3 could not explain why she did not document her observations of the wound on 7/28/20. She also stated she did not notify Resident #1's responsible party, or a facility provider of her observation or receive treatment orders from a provider. Nurse #3 reported she wrote a note on a piece of paper informing Nurse #2 of her observation of Resident #1's skin/open wound on her right foot and what she did to dress the wound. Nurse #3 stated she left a piece of paper in Nurse #2's box for her to review on 7/29/20. Nurse #3 reported this method of communication was used to inform the facility's wound nurse, Nurse #2, of observations of changes in skin condition, any new orders obtained, and treatment provided by the nurse. Nurse #3 indicated she thought she had informed Nurse #2 on 7/29/20 verbally of her observation and how she had dressed the open wound of Resident #1. Nurse #3 stated she assumed Nurse #2 found the piece of paper in her box. She stated NA #4 informed her that she also had informed the floor nurse. Nurse #3 stated she expected the floor nurse to have informed Resident #1's responsible party and the facility's medical provider of what been reported to him. Nurse #3 acknowledged she should have confirmed the facility's medical provider had been informed or she should have informed the facility's medical provider of her observation and care provided for Resident #1's open wound. Nurse #3 also acknowledged she should have received treatment orders by the provider on 07/28/20, prior to using an enzymatic debriding	F 600	Orders, Review of the daily Progress Notes, UDA, POC along with MAR/TAR. Director of Nursing will educate Clinical Staff on Skin Quick View, Use of Risk Management, Recognizing and Reporting Resident Change in Condition, Stop & Watch Program at orientation for new hires. Completion of this plan of correction is 9/18/2020. Monitoring: The Director of Nursing and Staff Development Coordinator will monitor the process of Clincial Morning Meeting five times a week for two weeks, then three times a week for two weeks, and then one time a week for four weeks. The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee meeting for three months consisting of the QA Committee and will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services. This Plan of Correction will be presented to the QAPI / IDT Team in the next scheduled meeting and monthly for 3 months for review and guidance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 9	F 600		

ointment on Resident #1's right foot open wound.

Resident #1's quarterly Minimum Data Set (MDS) dated 8/3/2020, revealed she was severely cognitively impaired, dependent on one person for activities of daily living, including personal hygiene. The MDS also identified Resident #1 was 2 persons assist with bed mobility and transfers. The MDS indicated she was at risk for pressure ulcers, but no pressure sores were present at the time of the assessment. The MDS identified Resident #1's weight to be 72 pounds.

Resident #1's care plan updated 8/3/2020 included focus areas for activities of daily living (ADL) self-care performance deficit, behavior problem related to refusing ADL care, at risk for further pressure ulcer development, and resident has wound infection of right lateral foot (initiated 8/11/20) with a goal that resident will be free of infection and interventions to administer antibiotics as ordered by provider.

A weekly skin review/assessment was completed by Nurse #4 on 8/04/2020 and noted Resident #1 had preexisting dry skin. No open areas were documented.

On 8/25/2020 at 10:30 AM during a phone interview Nurse #4 could not recall what had been observed on Resident #1's 8/04/2020 weekly skin review/assessment other than what had been documented.

A weekly skin review/assessment was completed by Nurse #2 on 8/10/2020 and indicated Resident #1 new open area/right lateral foot pressure ulcer. There were no measurements or further description of the area included on the skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 10	F 600		

assessment.

An interview was conducted with the facility's wound nurse, Nurse #2, on 8/20/2020 at 11:30 AM. Nurse #2 reported she has completed weekly skin review/assessments when the floor nurse had not been able to complete the task. On 8/10/2020, she completed the skin review for Resident #1 and observed a small open wound close to her toes on her right foot. She notified Resident #1's responsible party, a family member, of her observation and contacted Nurse Practitioner (NP) #1 and received telephone orders for an antibiotic and treatment orders. On 8/11/2020, she observed sloughing of the wound. Nurse #2 indicated another family member contacted the facility on 8/12/2020 and requested Resident #1 be transferred to the hospital. Nurse #2 reported she observed no signs of gangrene or foul odor from the wound prior to Resident #1 discharge from the facility. Also, during the interview with Nurse #2, she reported having no knowledge of, nor had received written or verbal communication of any skin breakdown for Resident #1 prior to her observation on 8/10/2020.

Record review of Resident #1's August 2020 medication and treatment administration records revealed nurse practitioner/physician telephone orders dated 8/11/2020 included an order for Bactrim (antibiotic) Double Strength 800 milligrams (mg) to 1600 mg twice a day for 10 days. In addition, an order was given to clean right lateral foot with wound cleanser, apply skin prep to peri wound, apply a sterile enzymatic debridement ointment to wound bed cover, cover with foam dressing every day shift for pressure ulcer. Resident to wear a protective boot at all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 11	F 600		

times.

The facility's hospital transfer summary sheet dated 8/12/20 at 6:24 PM indicated Resident #1 was afebrile and her vital signs were within normal limits. The document noted a skin wound or ulcer. Skin status evaluation - pressure ulcer/injury.

Resident #1's hospital admission record dated 8/12/2020, revealed, the chief complaint noted was a wound on the resident's right foot. On physical exam, Resident#1 was afebrile, awake, alert and in no apparent distress. Resident#1 was noted to present with a necrotic open foul-smelling wound on her lateral right foot with tendons exposed on her right fifth toe. The right fifth toe was noted to be necrotic and she had skin changes overlying the plantar and dorsal surface of the foot suggesting the ulcer had been there for quite some time. Resident#1 did have palpable pulses in the right foot. No overwhelming sepsis (infection). Orthopedics was consulted at a nearby sister hospital and the resident was transferred there and had a right below the knee amputation on 8/14/20.

An interview with the Director of Nursing (DON) was conducted on 8/24/2020 at 3:45 PM. The DON stated her expectation was for all nurses to complete a risk management assessment and notify the facility's medical providers of observations of changes in skin condition. The DON also stated Nurse #3 should have completed the risk management assessment on 7/28/2020 and notified Resident #1's responsible party, the facility's medical provider to obtain treatment orders for nursing staff to provide care for Resident #1's new area of skin breakdown.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 12	F 600		

During an interview on 8/25/2020 at 3:41 PM the facility's nurse practitioner (NP #1) confirmed she was notified by phone from Nurse #2 of an open wound on Resident #1's right foot while performing a weekly skin review. NP #1 did not assess Resident #1's new open wound virtually. NP #1 also stated in her professional opinion, a wound deterioration was most likely over a course of days. NP #1 stated based on Resident #1's medical history including chronic malnutrition, she was at risk for skin breakdown.

On 8/25/2020 at 3:48 PM an interview was conducted with the facility's medical director. He stated nurses should call to inform facility providers of new open skin areas in order to obtain treatment orders. The Physician reported Resident #1 was a risk for tendon exposure due to her comorbidities and adult failure to thrive. Regarding the hospital admission summary, the Physician stated gangrene can occur rapidly, over a few days. He also stated gradual discoloration could not be noticed right away and could have been overlooked by the nursing staff providing bathing, showering and skin care. Based on the description of the wound on 7/28/2020, the Physician stated the open wound sounded like a blister that erupted. He also stated the hospital records noted pulses in her lower extremities, therefore, he would not have expected a rapid deterioration of skin breakdown. The Physician stated with DTI (deep tissue injury) the tissue damage was not fast; the visualization of skin breakdown was rapid. The Physician concluded by stating the condition of Resident #1's skin had the potential for skin breakdown and was virtually unavoidable because of her risk factors. The Physician stated Resident #1 should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 600	Continued From page 13 followed by the wound nurse on a regular basis when the open foot wound was observed on 7/28/2020.	F 600		
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 review of the medical record and staff interviews the facility failed to accurately code a quarterly Minimum Data Set Assessment (MDS) for an opened area on a resident's foot for 1 of 3 sampled residents reviewed for providing care according to professional standards (Resident #1). The findings included: Resident #1 was readmitted to the facility on 2/10/20 with diagnoses which included; dementia, adult failure to thrive with severe protein/calorie malnutrition, type two diabetes mellitus, previous left below the knee amputation, chronic kidney disease stage 3, coronary artery disease with previous stent placement, remote history of stroke, and peripheral vascular disease. A progress note for Resident #1 written by Nurse #3 on 7/28/2020 and timed at 5:05 PM specified a nursing assistant (NA) informed Nurse #3, unit manager, of a new open area to the resident's right inner foot. The note also specified the area was cleaned and dressed and the wound care nurse and hall nurse were notified.	F 641	Resident affected: Resident #1 was discharged to the hospital. Residents with potential to be affected: All residents are at risk for deficient practice. All current, active resident minimal data set (MDS) for the last 30 days were reviewed for coding accuracy related to wounds. An audit was conducted by the Director of Nursing and Wound Care Nurse related to wounds on 9/18/2020. No coding errors were found as a result of the audit. Systemic Changes: Measure put in place to ensure the plan of correction is effective and remains compliant are: Effective 9/15/20, the MDS Coordinator was re-educated on accuracy of assessments and coding on the MDS related wounds. Education was provided by Director of Nursing and Regional Director of Clinical Services. Education will be a part of orientation and hiring	9/18/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 14 An interview was conducted on 8/24/2020 at 2:52 PM with NA #4. She stated while assisting Resident #1 with a shower on 7/28/2020, she observed a small sore on the side of her right foot. NA #4 stated she informed the floor nurse assigned to Resident #1 and Nurse #3 on the same day. She was not able to identify who the assigned floor nurse was at the time of the interview. NA #4 reported she observed a dressing on Resident #1's right foot on the following day. NA #4 stated after 7/29/2020 she did not observe any skin changes or dressings on Resident #1's right foot. On 8/24/2020 at 2:41 PM, an interview was conducted with Nurse #3. Nurse #3 reported that she was notified by NA #4 that Resident #1 had an open skin area on her right foot on 7/28/20. During the interview, Nurse #3 described the open skin area by stating the area looked like a blister that had ruptured at some point, no redness or swelling, no skin flap from possible rupture. She also stated the open skin area was red and beefy with clear drainage, maybe quarter sized. Resident #1's quarterly Minimum Data Set (MDS) dated 8/3/2020, revealed she was severely cognitively impaired, dependent on one person for activities of daily living, including personal hygiene. The MDS also identified Resident #1 was 2 persons assist with bed mobility and transfers. The MDS indicated she was at risk for pressure ulcers, but no pressure sores were present at the time of the assessment. The MDS identified Resident #1's weight to be 72 pounds. Section M1040 was not coded to reflect the opened area on her right foot.	F 641	process for future MDS Coordinator. Completion date for this plan of correction is 9/18/2020. Monitoring: Effective 9/15/20, Weekly audits will be conducted by the Director of Nursing and/or Administrator and MDSC nurse on new admits, risk management, 24 hour report and wound report to ensure accuracy of assessments. If modification is warranted, the resident will be scheduled for a new assessment. Audit will be conducted weekly for four weeks then monthly for three months. Results of audit will be brought to quarterly Quality Assurance and Performance Improvement meeting for three months. Review and revisions will be made as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 880	Continued From page 15	F 880		
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 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;	F 880		8/28/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 880	Continued From page 16 (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 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 observation, staff interviews, record review, and review of the facility's Covid Response Plan, the facility failed to implement their policies and procedures for 1 of 3 residents (Resident #4) by not placing a mask on a Covid positive resident during a room transfer reviewed for infection control. These failures occurred during a Covid-19 pandemic.	F 880	Resident affected: Corrective action accomplished for resident found to have been affected by deficient practice; 1. 8/20/20 a mask was placed on resident #4 to cover the mouth and nose when outside of the room. 2. 8/20/20 CNA #1 was re-educated on the facility COVID 19 infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 880	Continued From page 17 Finding included: A facility policy titled "Covid Response Plan", last revised June 2020 was reviewed. The policy read in part: All residents to wear masks if they come out of their rooms. Resident #4 admitted to the facility on 8/17/2015. His diagnoses included coronavirus. Resident #4 quarterly Minimum Data Set (MDS) dated 7/1/2020 revealed he had moderate cognitive impairments. He required total care with activities of daily living (ADL). Resident #4 had a revised plan of care dated 8/20/2020 related to Covid-19. His interventions were inclusive of supplying the resident with a face mask and encourage to wear if he must leave the room or be transported from the facility. An observation was completed of Resident #4 on 8/20/2020 at 10:01 AM. He was being transported in his wheelchair on the 200 hallway with no mask in place by NA #1. Resident #4 was Covid positive. Continued observation and interview with NA #1 revealed she was instructed to move Resident #4 to room 220 by the Administrator. She was not aware if Resident #4 had a mask or not. NA #1 further stated he should probably have on a mask. NA #1 went to retrieve Resident #4 a mask from his room. NA #1 placed the mask on Resident #4. She explained she had received training on infection control practices and Covid-19 inclusive of residents wearing masks while out of their rooms. Review of NA #1's education record revealed she	F 880	policy related to residents wearing mask. When outside their rooms, all current staff present on 8/20/20 were re-educated on the facility COVID 19 Infection Control policy related to residents wearing mask when outside of their rooms. This re-education was provided by the Staff Development Coordinator. Residents with potential to be affected: All residents are at risk for deficient practice; therefore, all staff were re-educated on the facility COVID 19 Plan related to resident wearing mask when out of their rooms. This re-education was provided by the Staff Development Coordinator on 8/28/2020. Systemic Changes: The Staff Development Coordinator re-educated 100% of the facility staff on the facility□s COVID 19 infection control policy related to resident wearing a mask to cover mouth and nose when outside of their room. The re-education was complete on 8/28/2020. All staff will be trained with the DHHS recommended video Closely Monitor Residents, by the Staff Development Coordinator by 9/30/20. These educations will be a part of the orientation for new hires. Monitoring: The Director of Nursing is responsible for the success of this plan of correction and will discuss the audit results to the monthly Quality Assurance and Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 880	Continued From page 18 received training on the Covid Response Plan on 7/28/2020 which included residents to wear masks when out of their rooms. A follow up observation of Resident #4 was completed on 8/20/2020 at 10:15 AM from the doorway of his room. The observation revealed Resident #4 continued to have his mask in place. An interview was completed with the Assistant Director of Nursing (ADON), who also served as the Staff Development Coordinator, on 8/20/2020 at 10:35 AM. The ADON explained the process should have been for NA #1 to place an N95 mask on Resident #4 prior to leaving his original room since he was Covid positive. NA #1 should have then transferred him to his new room on the Covid unit. The ADON verbalized staff have been trained and retrained on infection control practices, Covid-19, and ppe (Personal Protective Equipment). An interview was completed with the Administrator on 8/20/2020 at 11:15 AM. He explained everything happened pretty quickly once Resident #4's test results were received on 8/20/2020. The Administrator expressed he informed NA #1 that Resident #4 needed to be transferred to room 220 on the Covid unit. He communicated staff had been trained on infection control policies and procedures inclusive of residents wearing masks while out of their rooms. The Administrator verbalized he was not certain why NA #1 did not place a mask on Resident #4 prior to transporting him to his new room. The Administrator voiced all staff were being re-educated on residents wearing masks when leaving their rooms. He further voiced that NA #1 has already received re-education today	F 880	meeting for three months consisting of the QA Committee and will review the audits and ensure compliance is ongoing and determine the need for further audits/in-services. The Facility IDT Team will review this process five time a week in Clinical Morning Meeting and monitor any deficiencies which will be reported to the Administrator daily in Stand Up. The Interdisciplinary Team will record any deficiencies and follow up items needed to be completed by end of the day through the mask compliance book. This audit tool will be monitored five times a week for two weeks, then three times a week for two weeks, and then weekly for four weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 880	Continued From page 19 (8/20/2020) regarding residents having masks in place when leaving their room.	F 880		