PRINTED: 12/15/2020
FORM APPROVED
OMB NO. 0938-0391

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 11/17/2020

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 000	Initial Comments An unannounced complaint investigation, revisit and Covid 19 infection control survey was conducted on 10/27/20 through 11/17/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5HHY11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey, revisit and complaint investigation were conducted on 10/27/20 through 11/17/20. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID 5HHY11 2 of the 34 complaint allegations were substantiated but did not result in a deficiency. 5 of the 34 complaint allegations were substantiated resulting in deficiencies. 27 of the 34 complaint allegations were not substantiated. Immediate Jeopardy(IJ) began for F600 at K on 9/17/20. IJ removed on 11/05/20. Event ID 5HHY11. The revisit for F880 was conducted. Event ID 3LT012	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to	F 567		11/27/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/28/2020

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 567	Continued From page 1 manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:	F 567		

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F 567	Continued From page 2 Based on an observation, staff interview and resident interviews, the facility failed to allow a resident (Resident #2) to withdraw greater than $30 from his Resident Trust Fund account for 1 of 2 sampled residents reviewed for personal funds. The findings included: Resident #2 was admitted to the facility on 12/4/19 with diagnoses which included: Depression. Review of the Minimum Data Set (MDS) assessment dated 9/15/20 revealed the following regarding Resident #2: He was cognitively intact; he was independent or required supervision with setup help or one person physical assist for all activities of daily living. He had no impairment to his upper or lower extremities. During an interview with Resident #2 conducted on 10/27/20 at 12:14 PM, he stated that he was told by staff that he could not withdraw more than $30 each day, from his resident trust fund (RTF) account even though he had more than $30 in his account. An interview was conducted on 10/27/20 at 3:16 PM with Business Office Manager (BOM) #3. She stated withdrawals from the resident trust fund (RTF) were typically limited to $50 per day. She clarified if someone wanted to take more than $50, such as emptying their RTF out, she would obtain a check approval form. Once the check was approved the resident, or responsible party who had made the request, would receive a check for the requested amount. She stated when the stimulus money was received by the residents it was difficult at times to maintain	F 567	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. 1. Business Office, Receptionists have been IN serviced by Administrator on handling Resident Trust Policy. They have also been Inserviced that Resident #2 is allowed to withdraw the amount he wants if available and it is in his account. 2. On 11/24/2020 100% Audit was completed on alert and oriented residents to see if any trust fund issues. no negative issues. 3. A Resident Right audit will be conducted 2 x month for 2 months then monthly for 2 months. findings will be discussed in Qapi 4. Administrator is responsible for implementing acceptable plan of correction.	

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F 567	Continued From page 3 adequate funds on hand in petty cash and there had been times when they had run out of petty cash. She said when they run out of petty cash, she had to get the petty cash replenished which usually only took one business day. She stated Resident #2 typically received $50 each day. She said there had been an occasion when Resident #2 received $50 in the morning, the facility went through all of the available petty cash, he returned to the receptionist and requested another $50 in the afternoon, and the facility was unable to supply the requested amount and he had expressed dissatisfaction. The BOM stated that at the time of the interview the resident had $250 in his RTF. During an interview with Resident #2 conducted on 10/29/20 at 10:39 AM he stated he was unable to withdraw money from his RTF account. An observation was conducted on 10/29/20 at 10:45 AM of Resident #2 withdrawing funds from his RTF from the Receptionist. The resident asked the receptionist if he was able to withdraw more than $30 from his account? The receptionist told the resident he was unable to withdraw more than $30 from his account. The receptionist was observed to check what appeared to be a balance sheet with RTF amounts, removed $30 from the petty cash box, and then tended $30 cash to the resident. The receptionist then informed the resident if he wanted, he could return tomorrow, and she would be able to withdraw another $30 from his account for him. During an interview with Resident #2 on 10/29/20 at 10:48 AM he stated that he had wanted to withdraw more than $30 from his RTF, but the	F 567		

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F 567	Continued From page 4 receptionist would not allow him to withdraw more money. The resident stated he was upset about not being able to get more money because it was his money and he should have access to it. An interview was conducted on 10/29/20 at 10:50 AM with the Receptionist. The receptionist stated Resident #2 came to her almost every day to withdraw money from his RTF. She stated she told Resident #2 he could come back tomorrow, and he could get $30 more. The receptionist said $30 was the maximum amount she was allowed to withdraw from a resident ' s RTF each day. The receptionist stated she checked a balance sheet and Resident #2 had $245 balance remaining in his RTF account after the $30 withdrawal. During a phone interview with Administrator #2 and the Regional Director of Operations (RDO) on 11/6/20 at 2:36 PM it was stated that the expectation was for residents to be able to withdraw requested amounts of greater than $30 each day from their RTF.	F 567		
F 600 SS=K	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. §483.12(a) The facility must-	F 600		11/27/20

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F 600

Continued From page 5

§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 observation of recorded facility video, resident interview, staff interview, observation, and record review the facility failed to protect two of three residents reviewed for physical abuse (Resident #16 and Resident #17) from Resident #2. During a physical altercation on 9/17/20 Resident #2 struck Resident #16 with a closed right fist to the head and body repeatedly causing Resident #16 to experience a swollen lip. A staff member observed Resident #2 hit Resident #17 in the head with the open canopy of an umbrella, and then proceeded to hit Resident #17 in the leg with the closed umbrella. The facility also neglected to supervise Resident #2 to prevent him from providing a supervised smoker (Resident #16) with cigarettes. Resident #16 was at risk for injury due to unsafe smoking behaviors and required supervision while smoking. Resident #16 was observed smoking unsupervised on the patio on recorded video footage.

Immediate jeopardy began on 9/17/20 when Resident #2 was observed on facility security camera footage to have engaged in altercation with Resident #16 where Resident #2 was observed to have repeatedly punched Resident #16 numerous times to the face with a closed right fist. The punches delivered by Resident #2 to Resident #16 resulted in Resident #2 experiencing a swollen lip. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 11/4/20. The immediate

F 600

Resident #2 was placed on 1:1 on 10/30/20 by the Administrator for the protection of other Residents. Resident #2 will remain on 1:1 for the duration of stay or until Physicians and psychiatrists concur that the Resident no longer poses a threat to others. The administrator notified the staffing coordinator that resident #2 was placed on 1:1 and that she needs to assign a CNA to him every day for each shift. Resident assessed and changed to Supervised Smoker on 10/30/20 due to unsafe smoking behaviors. In order to expand the interdisciplinary problem solving, the facility is scheduling Psych Consult and meeting with Medical Director and Resident #2 to discuss recommendations for improved management of Behaviors.

On 10/30/2020, the Director of Nursing and Regional Clinical Consulted assessed all Residents that smoke to assure if supervision required. Staff were in-serviced on the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area. In-service was started on 10/30/2020 and was completed on 11/05/2020

On 10/30/2020 Maintenance Director applied an audible alarm to door adjacent

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F 600 Continued From page 6

jeopardy was removed on 11/5/20. The facility will remain out of compliance at a scope and severity level of E (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

The Findings Included:

1. Resident #2 was admitted to the facility on 12/4/19 with diagnoses which included: Depression.

Review of Resident #2's care plan dated 7/14/20 revealed focus area titled, the resident has limited physical mobility related to Chronic Obstructive Pulmonary Disorder (COPD) disease process and weakness. There was a sub-title which documented the resident had a motorized wheelchair and often unsafe: speeding, bumping into other residents, allowing or encouraging others to hang on and ride behind him. The goal was for the resident to demonstrate appropriate use of the motorized wheelchair to increase mobility through the review date. The listed interventions included; safety education and reminders related to motorized wheelchair use to be provided to resident as needed (slow speed, monitoring for other residents, and negotiating safely around them, not allowing other residents to hold on to back of his wheelchair for a free ride.

Review of the Minimum Data Set (MDS) assessment dated 9/15/20 revealed the following regarding Resident #2: He was cognitively intact; he was independent or required supervision with setup help or one person physical assist for all

F 600

to smoking area to alert staff if any Resident that is a supervised smoker attempts to go through door. The staff were in-serviced by Director Of Nursing, or Designee on the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area. In-service was started on 10/30/2020 and completed 11/05/2020.

Current staff education completed by Director of Nursing, Regional Nurse Consultant, Administrator, and RN Designee, including nursing, activities, Social Work, Dietary, Therapy, housekeeping and maintenance regarding Prevention of Abuse and/or Neglect. Staff unavailable on 11/05/20 will be in-serviced prior to being permitted to work. In-service will be provided to agency staff in writing prior to beginning of an assignment. New staff will receive education on this corrective action during orientation by the Director of Nursing and/or Assistant Business Office Manager. The Director of Nursing and the Assistant Business Office Manger were in-serviced on 10/30/2020 by the Administrator of the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area.

Current Staff education completed by Director of Nursing, Regional Nurse Consultant, Administrator, and RN Designee including nursing, activities, Social Work, Dietary, Therapy,

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F 600 Continued From page 7

activities of daily living. He had no impairment to his upper or lower extremities. The resident was documented as having weighed 337 pounds.

a. Resident #16 was admitted to the facility on 9/18/17 with diagnoses which included: Diffuse traumatic brain injury with loss of consciousness, hemiplegia (paralysis of one side of the body) of the left side of the body, depression, schizophrenia, delusional disorder, cognitive social or emotional deficit following unspecified cerebrovascular disease, anxiety, nicotine dependence, and generalized weakness.

Review of Resident #16 ' s care plan revealed a focus area most recently reviewed on 7/17/20 regarding the resident having had a seizure disorder related to a past head injury. Further review revealed focus areas including: Hemiplegia/hemiparesis related to head injury, the resident was deemed to be an unsafe smoker as of 6/16/20 due to the resident dozing off with a lit cigarette posing danger to himself and others, the resident had an Activity of Daily Living deficit related to left side hemiplegia, impaired cognitive function/dementia or impaired decision making in that the resident had lost money several times and was unable to recall what he did with the money, the resident received psychotropic medications related to schizophrenia and delusional disorder, anti-anxiety medications related to an anxiety disorder, and antidepressant medication related to depression.

Review of the Minimum Data Set (MDS) assessment dated 8/21/20 revealed the following regarding Resident #16: He was cognitively intact; he required limited assistance of one person for bed mobility, transfer (such as from a

F 600

housekeeping and maintenance regarding Smoking Policy. In-service started on 10/30/2020 and was completed on 11/05/2020 In-service will be provided to agency staff in writing prior to beginning of an assignment. New staff will receive education on this corrective action during orientation by the Director of Nursing and/or Assistant Business Office Manager. The Director of Nursing and the Assistant Business Office Manger were in-serviced on 10/30/2020 by the Administrator of the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area.

Staff education started on 10/30/2020 and completed 11/05/2020 by Director of Nursing, Regional Nurse Consultant, Administrator, and RN Designee including nursing, activities, Social Work, Dietary, housekeeping, Therapy and maintenance regarding Managing Difficult Behaviors, recognizing escalating anxiety and aggression that potentiates a risk to others, and what action should be taken when recognized . Staff unavailable on 11/05/20 will be in-serviced prior to being permitted to work.

Director of Nursing or Designee will monitor Smokers with quarterly and sig change assessments.

Maintenance Director will monitor door alarm 5x a week for 3 weeks and weekly for 3 weeks and monthly for 3 months.

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F 600	Continued From page 8 bed to a wheelchair), and locomotion off of the unit (how the resident moves to and returns from off unit locations). He had impairment to one side of his upper or lower extremities. The resident was documented as having weighed 179 pounds. Review of a 24-hour report dated 9/18/20 revealed an allegation Resident #2 had punched Resident #16 in the face while the two of them were in the smoking area on 9/17/20. The facility alleged they did not become aware of the altercation until 9/18/20 at 12:50 PM. The 24 hour report was signed by Administrator #1 on 9/18/20. The allegation type was classified as resident abuse and the local police department was documented as having been notified. A review was completed of the 5-working day investigation report dated 9/25/20. The review revealed the allegation of resident abuse when Resident #2 punched Resident #16 in the face on 9/17/20 was investigated, substantiated, and had caused harm to Resident #16, as evidenced by his lip being swollen. The summary of the investigation documented Resident #2 hit Resident #16 in the mouth while the two were at the smoking area. Resident #2 accused Resident #16 of taking two of his cigarettes, however Resident #16 denied the accusation. The report further documented due to Resident #2 ' s aggressive behavior, orders were received to send him to the hospital to be evaluated, and he refused to go. The local police department was contacted the officer instructed the facility to involuntary commitment papers for Resident #2. The officer was informed the resident was alert and oriented, and the officer directed the facility to press charges against Resident #2. Resident #16 went to the magistrate and pressed charges	F 600	Smoking Aids will be supervising smokers daily. results of all audits will be reviewed during qapi times 2 months. Administrator and Director of Nursing are responsible for implementing the acceptable plan of correction	

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F 600	Continued From page 9	F 600		

against Resident #2 and a warrant was issued for Resident #2. Resident #2 was placed on every 15 minute checks. An officer from the police department came to the facility to serve the warrant on 9/21/20 and the officer did not come into the facility and Resident #2 refused to meet the officer at the entrance. The officer returned on 9/22/20 and served the resident with a summons to appear in court on 10/25/20. The resident was documented to remain on every 15 minute checks. The report was signed by Administrator #1 on 9/25/20.

An observation of facility security camera footage from 9/17/20 and timed 3:33 PM was conducted in conjunction with an interview with the Maintenance Director (MD) and the Maintenance Assistant (MA) on 10/28/20 at 2:33 PM. The video did not have audio and was black and white video. Resident #2 was in his electric wheelchair and Resident #16 was in a manual wheelchair with an ash tray on his lap. Resident #2 rolled up to Resident #16 ' s right side and got within inches Resident #16 and leaned toward Resident #2. Resident #2 then propelled his electric wheelchair to the point where he had to spread his knees apart to get even closer to Resident #16 then reached with his left hand and pulled a cigarette shaped object from behind Resident #16 ' s right ear. Resident #2 then tried to roll away and Resident #16 grabbed Resident #2 ' s left hand with his right hand. Resident #16 continued to hang onto Resident #2 ' s left hand as Resident #2 backed away from him. Resident #2 then started to use his right hand to punch Resident #16 in the face. Resident #16 then backed up and Resident #2 propelled at him with his hands held up in a boxing type position, Resident #16 took the ash tray with his right hand

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F 600	Continued From page 10 and attempted to strike Resident #2 as he propelled toward him. Resident #2 got within an arm ' s length of Resident #16, grabbed Resident #16 ' s right arm, attempted to make several punches with his right arm as he attempted to hold Resident #16 ' s right arm with his left hand, the ash tray fell to cement patio, Resident #16 attempted to strike at Resident #2 as Resident #2 continued to use both of his arms in an attempt to grab Resident #16 ' s right arm while he punched Resident #16 in the head. Eventually Resident #2 succeeded in holding Resident #16 ' s right arm and proceeded to make 5-6 direct punches to Resident #16 ' s head and knocked the hat off Resident #16 ' s head. Resident #2 then used his electric wheelchair to move away from Resident #16. Resident #16 then moved toward Resident #2 slightly and attempted, unsuccessfully to strike at Resident #2. Resident #2 then again propelled toward Resident #16 within arm ' s length, and again used his left hand to grab Resident #16 ' s right arm, and then delivered punches too numerous to count to his head. Resident #2 then backed up again, repositioned himself in his electric wheelchair, and again got within arm ' s length of Resident #16, again grabbed his Resident #16 ' s right arm with his left hand and proceeded to deliver punches to Resident #16 ' s head too numerous to count with his right fist. Resident #2 backed away from Resident #16 again, repositioned himself in his wheelchair, and repeated the same maneuver again where he rolled up to within arm ' s length of Resident #16, used his left hand to hold Resident #16 ' s non-affected arm, which was his right arm, and then proceeded to punch Resident #16 in the face several more times. Resident #2 backed away from Resident #16 again and repositioned himself in his wheelchair. It appeared as	F 600		

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 11/17/2020

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 600 Continued From page 11 F 600

Resident #2 said something to Resident #16 and then Resident #16 rolled toward Resident #2 and attempted to kick him with his right leg. Again, Resident #2 repeated rolling up to Resident #16 within arm ' s length, grabbed Resident #16 ' s right arm with his left hand, and this time pulled his upper body toward him and started to repeatedly punch Resident #16 to the head while twisting Resident #2 ' s right arm. Resident #2 backed his wheelchair up and repositioned himself in the chair. Resident #2 then uses his electric wheelchair to go around the smoking area and then returns inside of the building. The first strike from Resident #2 to Resident #16 occurred at video mark 3:33:30 PM and the last strike from Resident #2 to Resident #16 was at video mark 3:36:29 PM. Additionally observed in the video, Resident #19 was observed to have witnessed the entire altercation. At the conclusion of the video the Maintenance Director stated he was the only one who had access to the facility video surveillance system, and he stated neither he nor anyone else had observed the just viewed video footage prior to that viewing.

During an interview with Resident #16 conducted on 10/29/20 at 2:46 PM he stated Resident #2 had accused him of stealing two cigarettes, he punched me in the lip, and we got into it, he ' s bigger than me, he has two arms and I only have one. The resident continued and stated they kept swinging at each other, he kept hitting me in the head, and then he tried to use his one good hand to punch him in the stomach. Resident #16 explained Resident #2 had punched him first and he had just been sitting there when Resident #2 had come up to him and started accusing him of having stolen cigarettes. Resident #16 stated during the altercation Resident #2 had taken two

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 11/17/2020

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 600	Continued From page 12	F 600		

cigarettes from him. He said Resident #2 kept punching him in the head and he had a busted and swollen lip from being punched in the face. He said he was trying to defend himself with his right hand but Resident #2 was holding it because he knew he couldn ' t use his left arm to defend himself. He stated it upset him a lot that Resident #2 had held his one good hand and continued to punch him knowing he couldn ' t use his left hand. He said he felt like Resident #2 was continuing to try to intimidate him because just last night when he was in the day room, Resident #2 went past him and with his electric wheelchair hit the anti-tip bars on the back of his wheelchair and it had upset him. He stated he felt like Resident #2 would hit him again

An interview was conducted on 10/27/20 at 12:14 PM with Resident #2. During the interview the resident stated he was supposed to go to court because Resident #16 had placed a warrant out for his arrest due to an altercation he had with him. The resident stated the altercation was due to him having accused Resident #16 of having stolen his cigarettes. The resident stated he was unable to recall the date of the altercation.

An interview was conducted with Resident #19 on 10/28/20 at 2:52 PM. He stated he remembered Resident #2 had sold two cigarettes to Resident #16 in the morning and then he stated Resident #2 accused Resident #16 of stealing two cigarettes from him. He stated he recalled that Resident #16 had tried to hit Resident #2, Resident #2 caught Resident #16 ' s hand and then hit him back. He said the two of them continued to argue and hit at each other. He said it was a scary 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 11/17/2020

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 600	Continued From page 13	F 600		

A phone interview on 10/30/20 at 2:19 PM was conducted with the Occupational Therapist (OT) who was working with Resident #16. She stated Resident #16 had asked her to pull down his mask on 9/18/20 to see if his lip was cut. She stated she asked the resident what had happened, and he replied Resident #2 had hit him and accused him of stealing two cigarettes, but he said he had not stolen the cigarettes. She stated the resident ' s lip was swollen and did have a cut on the inside of his mouth on his bottom lip. The OT said the resident did not complaint of pain anywhere else except for his lip and that it was sore. Review of the witness statement from the OT, which was an email dated 9/18/20 and timed 2:49 PM, Resident #16 also informed her Resident #2 had been in another fight on 9/18/20. She further stated she informed her supervisor of the information Resident #16 had shared with her.

The resident had a physician ' s order dated 9/18/20 and timed 12:56 PM for Resident #2 to be sent to the ER via ambulance for evaluation with psych services for combative behaviors.

A nursing progress note dated 9/18/20 and timed 2:36 PM by Nurse #1 documented it had been reported by Resident #16 that Resident #2 had hit him while they were both at the smoking area on 9/17/20. The note further documented orders were obtained to send Resident #2 to the Emergency Room (ER) for evaluation of aggressive behavior and the resident refused to go to the ER. An order was received for the Resident #2 to be placed on every 15 minute checks and those were initiated.

Review of a progress note written by the Nurse

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 11/17/2020

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 600	Continued From page 14 Practitioner (NP) dated 9/23/20 and timed 11:45 AM revealed she had conducted a remote visit with the resident on 9/22/20. She documented she spoke with the resident about his aggressive behaviors and discussed the use of medication for feelings of depression or other symptoms of mood changes. The resident responded with a statement of, ' I ' m fine and I don ' t need nothing." The NP documented she further discussed an order for a psychiatric evaluation and the resident refused to see psychiatric services or sign the consent form to see psychiatric services. The NP documented 15 minutes checks were to be continued along with staff monitoring od behaviors in the smoking area. An NP noted dated 9/29/20 by the NP documented the facility staff stated the resident had displayed aggression and continued to misuse his electric wheelchair. The NP documented the resident at first declined a psychiatric referral, but then agreed to it, and signed the necessary paperwork. The psychiatric referral was to evaluate aggressive behaviors. The NP further documented the resident was provided education regarding the safe use of his electric wheelchair and if he was unable to use the electric wheelchair safely, the electric wheelchair would be taken. The resident was documented as agreeing to take Sodium Valproate for mood disorders until he was able to have the psychiatric referral completed due to his aggressive behaviors. The resident was documented as verbalizing understanding of safety precautions as related to the wheelchair, agreed to the psychiatric referral, and agreed to starting the new medications for his mood disorders.	F 600		

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 11/17/2020

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

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F 600	Continued From page 15	F 600		

Review of a Physician Progress note dated 10/8/20 by Resident #2 ' s physician documented the staff reported increasing aggression behaviors.

A phone interview was conducted with the NP on 10/30/20 at 12:13 PM. She stated she had placed the resident on Sodium Valproate (a medication used to treat bipolar disorder) to help control Resident #2 ' s mood. The NP said she had received reports the resident had become very aggressive both physically and verbally. She said she started the medication on 9/29/20 and added she had tried to start him on the medication earlier, but he had refused. The NP stated the resident was very manipulative and he would say one thing and then do another. The NP stated she believed the psychiatric consult, which she had ordered on 9/29/20, and the resident agreed to, needed to be completed as soon as the facility can get it done.

During an interview conducted on 10/27/20 at 4:45 PM with Social Work (SW) #1 and SW #2 it was stated Resident #2 had inappropriate behaviors including resistive to care, and aggression towards other residents. The SWs stated the resident was cognitively intact, so he was re-educated on how to treat other residents and praised for following directions. Resident #2 was placed on every 15 minute checks after the altercation was discovered and he remains on the 15 minute checks. It was further stated the resident was referred to psychiatric services but due to the resident having had intact cognition, the resident refused, and the referral was cancelled. SW #1 stated Resident #16 was taken to the magistrate and he pressed charges against

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 11/17/2020

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 600	Continued From page 16	F 600		

Resident #2 for the altercation which took place in September. The originally scheduled court date was 10/25/20, but that date was cancelled, and they are awaiting word from the DA about another scheduled court date.

Review of an email from the psychiatric evaluation company dated 10/29/20 and timed 3:52 PM revealed communication the company had received the referral for Resident #2. The resident had yet to be picked up by their services, but he will be on the schedule to be seen at the next visit.

During an interview with Resident #2 conducted on 10/30/20 at 11:20 AM Resident #2 stated Resident #16 had tried to bite him during the altercation on 9/17/20 regarding Resident #16 having allegedly stolen two of his cigarettes. Resident #2 further stated, smiling and laughing as he made the statement, he then helped his fist into Resident #16 ' s mouth for him a few times. Resident #2 stated he had never given cigarettes to Resident #16.

During an interview with Administrator #1 conducted on 10/28/20 at 5:41 PM she stated she had not observed the video of the altercation from 9/17/20 involving Resident #2 and Resident #16. Administrator #1 further stated usually video footage was automatically deleted after 30 days and she was not aware of how long the video footage was saved for.

During an interview with Smoking Aide (SA) #2 on 10/28/20 at 4:53 PM she stated Resident #2 would make derogatory and inappropriate comments to Resident #16; such as statements like, oh go tell your daddy, referring to Resident

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F 600	Continued From page 17	F 600		

#17 as Resident #16 ' s father.

During a phone interview with Administrator #2, who replaced Administrator #1 on 11/2/20, and the Regional Director of Operations (RDO) on 11/6/20 at 2:36 PM it was stated by Administrator #2 it was the expectation for administration to be notified promptly of all allegations of abuse and for the allegations to be investigated promptly. The Administrator further stated Resident #2 was placed on 15 minute checks as of 9/18/20 to monitor him for inappropriate behavior. She further stated Resident #2 was started on 1:1 supervision by a staff member as of 10/30/20 and remained on 1:1 supervision. During the period of 1:1 supervision he had not been observed to exhibit inappropriate behaviors. The Administrator said Resident #2 was moved from the 100 hall to the 200 hall and placed in a different room which she believed had also helped to alleviate inappropriate or aggressive behavior. Both the RDO and the administrator stated Resident #2 was completely alert and oriented which had made putting interventions in place challenging.

b. Review of the facility policy titled "Smoking Policy-Residents," which had an effective and last reviewed date of 2/1/20, revealed a safe smoking evaluation was to be conducted upon admission, quarterly, and as needed for all residents who smoked. The evaluation included disease/diagnosis impacting smoking safety, fire safety, and history of smoking related incidents. The policy documented no resident, regardless of designation, was permitted to possess smoking materials outside of the designated smoking area. The risk factors and interventions that were identified on the evaluation would be documented

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 11/17/2020

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 600 Continued From page 18
on the resident ' s care plan.

Review of a Safe Smoking Assessment for Resident #16 dated 6/16/20 revealed the resident was deemed not to be a safe smoker due to exhibiting signs of confusion, inability to verbalize or demonstrate an understanding of the smoking policy, inability to verbalize or demonstrate an understanding of the smoking times and places to smoke, inability to remain alert during the course of smoking at all times, and the resident was documented as requiring supervision while smoking. There was an addendum to the smoking policy, with a revision date of 04/2020, which stated; All smokers, except Independent-Safe Smokers, are supervised while smoking.

Review of Resident #2 ' s care plan, dated 7/14/20, revealed no focus area or intervention regarding him being a smoker.

An observation of facility security camera footage from 9/17/20 and timed 11:33 AM was conducted in the presence of the MD and the MA on 10/28/20 at 2:33 PM. The video did not have audio and was black and white video. Resident #16 was observed to have received 2 cigarette shaped objects from Resident #2. Resident #16 was then observed to have smoked the cigarettes with no visible staff supervision. Later in the video, at 3:30 PM prior to the altercation with Resident #16, Resident #2 was observed to have been smoking and was holding an ash tray in his lap. During the altercation Resident #2 was observed to have removed a cigarette shaped object from Resident #16 ' s right ear. After the altercation, Resident #16 was observed to have withdrawn another cigarette and was holding it in

F 600

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 11/17/2020

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 600	Continued From page 19	F 600		

his hand with no observed staff supervision.

During an interview with Resident #16 on 10/27/20 at 4:24 PM he said he was waiting to go outside and smoke because he had to have someone watch him go out and smoke. There was a cigarette round shaped singed hole in the splint on his left hand and the resident stated he had burned it about a month ago. The resident stated he was an unsupervised smoker at the time when he had burned his splint. He stated the cigarettes he had during the altercation, on 9/17/20, were his, and he had not taken them from Resident #2.

An interview was conducted with SA #1 on 10/30/20 at 11:15 AM. The SA stated Resident #2 handed out smoking supplies to other residents, including residents who were supervised smokers. She stated she had reported Resident #2 handing out smoking supplies to the nurse. Regarding Resident #16, she stated he tried to go outside and smoke frequently while unsupervised. She said he is a supervised smoker but will go outside and get cigarettes from other residents or even purchase cigarettes from other residents. She said she had caught him with cigarettes frequently and she had reported it to his nurse about him having cigarettes even though he was a supervised smoker. She further stated when she was not out there for supervised smoking times she would look to see if he was out in the smoking area when she happened to pass by the area.

An observation of Resident #2 on 10/30/20 at 11:18 AM revealed him not being cooperative with storing smoking materials as per what SA #1 was asking him to return his smoking materials to her

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 11/17/2020

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 600	Continued From page 20	F 600		

instead of keeping them on his person. Resident #2 proceeded to argue with SA #1 and attempted to stow cigarettes and other smoking materials in his shirt.

During an interview with Resident #2 conducted on 10/30/20 at 11:20 AM Resident #2 stated he gave out cigarettes to other residents.

During an interview conducted on 10/28/20 at 3:43 PM Nurse #3 stated Resident #2 was constantly giving out cigarettes to other residents. She said she had talked to him about his behaviors several times, but the resident would do what he wanted to despite being told of the rules.

During a phone interview with Administrator #2 and the Regional Director of Operations (RDO) on 11/6/20 at 2:36 PM it was stated the expectation for administration to be notified promptly of all allegations of abuse and for the allegations to be investigated promptly. The Administrator further stated Resident #2 was placed on 15 minute checks to monitor him for inappropriate behavior. She further stated Resident #2 was currently on 1:1 supervision by a staff member and had not been observed to exhibit inappropriate behaviors. The Administrator said Resident #2 was moved from the 100 hall to the 200 hall and placed in a different room which she believed had also helped to alleviate inappropriate or aggressive behavior. The Administrator stated due to Resident #2 ' s non-adherence to the smoking policy, Resident #2 had been made a supervised smoker. Both the RDO and the administrator stated Resident #2 was completely alert and oriented which had made putting interventions in

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 11/17/2020

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 600	Continued From page 21	F 600		

place challenging.

c. Resident #17 was admitted to the facility on 2/21/20 with diagnoses which included: Schizoaffective disorder, dementia, depression, and a pathological fracture of the hip.

Review of the Minimum Data Set (MDS) assessment dated 8/26/20 revealed the following regarding Resident #17: He had severe cognitive impairment; he was independent and required no setup or physical help from staff for all ADL ' s except for personal hygiene which he required supervision and setup help and bathing which he was totally dependent for. He was coded for no behaviors. He had no impairment to his upper or lower extremities. The resident was documented as having weighed 195 pounds.

Resident #17 ' s care plan, which was most recently reviewed on 8/26/20, had a focus are documenting Resident #17 had impaired cognitive function/dementia as well as delusional thinking. Further review revealed a focus area regarding the resident receiving antipsychotic medications related to behavior management.

Review of a 24-hour report dated 9/18/20 revealed an allegation Resident #2 had hit Resident #17 in the chest and poked him with an umbrella on the 100 hallway on 9/18/20. The 24 hour report was signed by Administrator #1 on 9/18/20. The allegation type was classified as resident abuse and the local police department was documented as having been notified.

A review was completed of the 5-working day investigation report dated 9/25/20. The review revealed the allegation of resident abuse when

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 11/17/2020

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 600 | F 600

Continued From page 22
Resident #2 hit Resident #17 in the chest and poked him with an umbrella on 9/18/20 was investigated and substantiated. The summary of the investigation documented Resident #2 hit Resident #17 in chest and poked him with an umbrella. It was reported by another resident, Resident #17 had taken Resident #2 ' s umbrella. Resident #2 denied hitting or poking Resident #17 with his umbrella. Resident #17 was assessed and was found to have not experienced any visible injuries. Administrator 1 documented she contacted the local police department regarding a previous incident regarding Resident #2 and the officer instructed the Administrator to file involuntary commitment papers for Resident #2. The Administrator informed the officer that Resident #2 was alert and oriented and the officer responded the facility needed to press charges against Resident #2. It was further documented Resident #2 was placed on every 15 minute checks and the resident had displayed no inappropriate behaviors since the 15 minute checks were initiated. The administrator further documented the resident had a court date on 10/25/20 regarding a previous incident.

During an interview with SA #2 on 10/28/20 at 4:53 PM she stated she had observed an incident between Resident #2 and Resident #17 in the morning on 9/18/20. She stated it was raining and Resident #2 had gone out on the sidewalk in the courtyard in his electric wheelchair and had an umbrella to protect him from the rain. She said when Resident #2 returned to the covered smoking area from the sidewalk, he still had his umbrella up, and purposefully went out of his way to run the canopy part of the umbrella into Resident #17 ' s face. She told Resident #2 that was inappropriate and not to do that and then

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 11/17/2020

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

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F 600	Continued From page 23	F 600		

Continued From page 23

Resident #2 proceeded to retract the umbrella, turned his electric wheelchair around, and returned to Resident #17 and proceeded to hit him on the leg with the closed umbrella. The SA said she was telling Resident #2 to stop and was saying his name and the resident responded to her by imitating and mocking her saying his name as if she were saying it. The SA stated she had reported it to Nurse #2. She said the nurse asked her for a written statement and had made a report.

During an interview with Resident #16 conducted on 10/29/20 at 2:46 PM he stated he was out on the smoking patio the day Resident #2 and Resident #17 had an altercation. He recalled the day after he and Resident #2 were in an altercation, 9/17/20, which would have been 9/18/20, Resident #2 got into a fight with Resident #17 about an umbrella in the evening. He stated Resident #2 told Resident #17 to "Leave his damn umbrella alone, you son of a b*tch." He said Resident #17 kept backing up and Resident #2 kept driving his electric chair towards him. He said he could not see what happened next because when Resident #17 was backing up and Resident #2 was going toward him they went far enough away where he was unable to see what happened.

Resident #2 was interviewed on 10/30/20 at 11:15 AM and he stated Resident #17 had stolen his umbrella and so he swung at Resident #17. Resident #2 stated Resident #17 was "not all there" and acted inappropriately sometimes.

Review of a nursing progress note in Resident #17 ' s electronic medical record (EMR) with an effective date of 9/18/20 and timed 4:30 PM,

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 11/17/2020

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ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 600	Continued From page 24	F 600		

written by Nurse #2, revealed it was reported to the nurse Resident #17 had an altercation with Resident #2. It was reported Resident #17 picked up Resident #2 ' s umbrella, not knowing it belonged to Resident #2. It was further reported Resident #2 got the umbrella from Resident #17, hit Resident #17 with the umbrella, and then tried to dump Resident #17 out of his wheelchair. No injury was discovered on Resident #17.

An interview was conducted on 10/28/20 at 4:00 PM with Nurse #2. The nurse stated it had been reported to her Resident #17 was trying to protect himself from Resident #2 on 9/18/20 but she thought it may have occurred during the evening of 9/17/20. The nurse stated someone from the other side had reported it and she did not know who had reported it. She said she did not believe there were any staff who had reported the altercation. The nurse stated it was reported to her that Resident #2 had hit Resident #17 with his umbrella, tried to dump Resident #17 out of his chair, and Resident #17 fell from his chair. She said she assessed Resident #17 on 9/18/20 and she did not discover any injuries. The nurse said Resident #2 was on the 100 hall at the time and they were trying to keep him away from Resident #17, who resided on the 200 hall. The nurse stated Resident #2 rode in his electric wheelchair all over the whole building.

Review of a behavior note from the EMR of Resident #2 with a created date of 9/21/20 at 9:55 PM and an effective date of 9/21/20 at 8:48 PM written by Nurse #3 revealed Resident #2 was out of his room several times during the 3:00 PM to 11:00 PM shift and the nurse received a call at 8:30 PM that Resident #2 was over on the 200 hall "goading" Resident #17 to come outside.

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 11/17/2020

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ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 600	Continued From page 25	F 600		

The resident stated Resident #17 started it by taking an umbrella apart and was stabbing Resident #2 with the rod part. Resident #2 was documented as having been on 15 minute checks. The NP was notified, and she stated she wanted to see the resident the next time she was at the facility.

An interview was conducted on 10/28/20 at 3:43 PM with Nurse #3. The nurse stated Resident #2 can be very abusive and she was aware he had hit another resident in the nose and the other resident had a warrant for the arrest of Resident #2. The nurse stated it was reported to her Resident #2 accused Resident #17 of taking an umbrella apart and trying to poke him with it. The nurse stated she nor the nurse who had reported the altercation to her were able to discover the umbrella, and no injuries were discovered on Resident #2. She further stated she contacted the NP and she stated she was going to see him tomorrow, ordered labs, and ordered a psychiatric consult. The nurse said the resident was on 15 minute checks and continued 15 minute checks. She said she felt the behaviors of Resident #2 were escalating, getting worse, and the other residents of the facility try to stay clear of him.

During a phone interview with Administrator #2 and the Regional Director of Operations (RDO) on 11/6/20 at 2:36 PM it was stated it was the expectation for administration to be notified promptly of all allegations of abuse and for the allegations to be investigated promptly. The Administrator further stated Resident #2 was placed on 15 minute checks to monitor him for inappropriate behavior. She said they had become aware of the incident involving Resident #16 and Resident #17 on the same day. She

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	345115	A. BUILDING ______ B. WING ______	C 11/17/2020

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ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 600	Continued From page 26	F 600		

further stated Resident #2 was currently on 1:1 supervision by a staff member and had not been observed to exhibit inappropriate behaviors. The Administrator said Resident #2 was moved from the 100 hall to the 200 hall and placed in a different room which she believed had also helped to alleviate inappropriate or aggressive behavior. Both the RDO and the administrator stated Resident #2 was completely alert and oriented which had made putting interventions in place challenging.

Administrator #1 was made aware of the Immediate Jeopardy (IJ) on 10/30/20 at 4:02 PM.

On 11/4/20 at 3:40PM, the facility shared the following plan to address the incident:
IJ removal
Incident date 9-17-20

F600-Abuse/Neglect
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

On 9/17/2020 Resident #2 and Resident #16 were in the smoking area. Per camera footage it was observed that Resident #2 tried to remove a cigarette from behind the ear of Resident #16. Resident #16 reached out and lunged at Resident #2 which resulted in Resident#2 striking Resident #16 with a closed fist to head and body while holding his unaffected arm with his left hand. Resident #2 and Resident #16 continued to exchange punches. Resident #2 stopped swinging at Resident #16, however Resident #16 threw the ash tray and attempted to kick at resident #2 which caused resident #2 to begin hitting resident #16 again. Resident #2 continued

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F 600	Continued From page 27	F 600		

to hit Resident #16 in the face with his fist which resulted in a swollen lip to Resident #16.

Resident #2 has a Brief Interview for Mental Status of 15 and has no impairment/limited mobility to his upper or lower extremities. DX: Depression, Mood Disorder.

Resident #16 has a Brief Interview for Mental Status of 15 with impairment/limited mobility of one side of his upper and lower extremities. DX: TBI, Hemiplegia, Epilepsy, Depression, Schizophrenia, Delusional Disorder, Cognitive social emotional deficit following stroke, anxiety, nicotine dependence.

Administrator notified of altercation on 9/18/20 by the facility Social Worker #1. Facility notified resident #16 emergency contact of the incident. Emergency contact stated that she wanted to know who the resident was that assaulted her son and that the facility needed to press charges. Administrator explained to emergency contact that we could not give her that information; however, the facility was working on the situation. Administrator notified Police of Resident #2 aggressive behaviors whom refused to come into the facility due to COVID. They were advised to involuntarily commit which was also unsuccessful. Facility was informed that if resident #16 would press charges that a warrant for resident #2 would be issued and resident would be arrested. Resident #16 was transported to the magistrate ' s office to press charges. Resident #2 was placed on Q 15minute checks until Salisbury Police Department picked up resident. Upon returning to facility on 09/21/2020, it was determined that the Salisbury Police Department had not picked up resident #2.

F 600 Continued From page 28 F 600

Facility attempted to call and follow-up on why resident wasn ' t picked up and was informed an officer was on his way to the facility. Upon arrival to facility the Officer stated he had a summons for the resident #2 and requested that the resident come outside to be served. Resident #2 refused to come outside, and the officer refused to enter the building. The officer left to get more direction from his superior, upon returning to the facility the officer still refused to enter the facility and resident #2 refused to come outside. Facility also reached out to the ombudsman on 09/21/2020 regarding resident #2. On 09/22/2020, the officer returned, entered the building resident #2 was served with a summons to appear in court for assault. Resident remained on Q15 minute checks which is conducted by residents assigned CNA, charge nurse, unit manager and/or director of nursing on a Q 15-minute log that is kept in a notebook that is specific to resident #2.

During afternoon of 9/18/20 per interview with smoking aide, Resident #2 was observed by staff to have an open umbrella and while riding in his electric power chair and hit Resident #17 in the head. Resident #2 then closed the umbrella and proceeded to strike Resident #17 on the leg. Resident sustained no injuries.

Deficient practice occurred at the point where the facility failed to prevent resident #16 from entering the smoking area due to him being a supervised smoker. All Residents at risk due to aggressive behavior of Resident #2 as well as unsafe smoking behaviors.

Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when

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 11/17/2020

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F 600	Continued From page 29	F 600		

the Action will be complete.

Resident #2 was placed on 1:1 on 10/30/20 by the Administrator for the protection of other Residents. Resident #2 will remain on 1:1 for the duration of stay or until Physicians and psychiatrists concur that the Resident no longer poses a threat to others. The administrator notified the staffing coordinator that resident #2 was placed on 1:1 and that she needs to assign a CNA to him every day for each shift. Resident assessed and changed to Supervised Smoker on 10/30/20 due to unsafe smoking behaviors. In order to expand the interdisciplinary problem solving, the facility is scheduling Psych Consult and meeting with Medical Director and Resident #2 to discuss recommendations for improved management of Behaviors.

Residents with Behaviors will continue to be reviewed at weekly Risk/Behavior meetings and changes and/or aggression will be addressed and care plan updated. The Minimum Data Set nurse will update residents care plan and document so that it triggers to the Kardex for the CNAs to be notified of any changes.

On 10/30/2020, the Director of Nursing and Regional Clinical Consulted assessed all Residents that smoke to assure if supervision required. Staff were in-serviced on the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area. Inservice was started on 10/30/2020 and was completed on 11/05/2020. On 10/30/2020 Maintenance Director applied an audible alarm to door adjacent to smoking area to alert staff if any Resident that is a supervised smoker attempts to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 600 Continued From page 30 F 600

go through door. The staff were in-serviced on the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area. Inservice was started on 10/30/2020 and completed 11/05/2020.

All staff education completed by Director of Nursing, Regional Nurse Consultant, Administrator, and RN Designee, including nursing, activities, Social Work, Dietary, Therapy, housekeeping and maintenance regarding Prevention of Abuse and/or Neglect. Staff unavailable on 11/05/20 will be in-serviced prior to being permitted to work. Inservice will be provided to agency staff in writing prior to beginning of an assignment. New staff will receive education on this corrective action during orientation by the Director of Nursing and/or Assistant Business Office Manager. The Director of Nursing and the Assistant Business Office Manger were in-serviced on 10/30/2020 by the Administrator of the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area.

All Staff education completed by Director of Nursing, Regional Nurse Consultant, Administrator, and RN Designee including nursing, activities, Social Work, Dietary, Therapy, housekeeping and maintenance regarding Smoking Policy. Inservice started on 10/30/2020 and was completed on 11/05/2020 Inservice will be provided to agency staff in writing prior to beginning of an assignment. New staff will receive education on this corrective action during orientation by the Director of Nursing and/or Assistant Business Office Manager. The Director

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	345115	A. BUILDING ______ B. WING ______	C 11/17/2020

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ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 600	Continued From page 31	F 600		

of Nursing and the Assistant Business Office Manger were in-serviced on 10/30/2020 by the Administrator of the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area.

Staff education started on 10/30/2020 and completed 11/05/2020 by Director of Nursing, Regional Nurse Consultant, Administrator, and RN Designee including nursing, activities, Social Work, Dietary, housekeeping, Therapy and maintenance regarding Managing Difficult Behaviors, recognizing escalating anxiety and aggression that potentiates a risk to others, and what action should be taken when recognized . Staff unavailable on 11/05/20 will be in-serviced prior to being permitted to work. Inservice will be provided to agency staff in writing prior to beginning of an assignment. New staff will receive education on this corrective action during orientation by the Director of Nursing and/or Assistant Business Office Manager. The Director of Nursing and the Assistant Business Office Manger were in-serviced on 10/30/2020 by the Administrator of the smoking policy which included updates on supervised smokers, the smoking area, and the audible alarm to the door adjacent to the smoking area.
On 10/30/20 Social Services met with Resident #16 and #17 to assure psycho-social wellbeing and any needs met.

The facility alleges removal of the Immediate Jeopardy as of 11/05/20.

As part of the validation process on 11/9/20 the plan of correction was reviewed and included the in-services related to abuse, resident smoking

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	345115	A. BUILDING ______ B. WING ______	C 11/17/2020

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

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F 600	Continued From page 32 policy, education regarding updates for the residents who were supervised smokers, resident rights, staff burnout and dementia care for all staff members, documentation that revealed 100% of all residents alert and oriented were interviewed regarding concerns about safety/abuse, in-house residents had a skin assessment conducted, employee files were reviewed to verify background checks and abuse training was completed upon hire, the grievance logs were reviewed to verify no complaints related to abuse were reported, and the QAPI plan to include monitoring to be completed. Date of IJ removal was verified as 11/5/20.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation of recorded facility video, resident interview, staff interview, and record review the facility failed to implement their Elder Justice Act (abuse/neglect) Policy in the area of investigation for one of three facility abuse investigations reviewed (Resident #2 and	F 607	1.11/05/2020 Regional Director of Operations IN serviced Administrator on Facility policy titled abuse neglect and exploitation. also how to do a through investigation. Resident #2 was placed on 1-1's on	11/27/20

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 11/17/2020

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ACCORDIUS HEALTH AT SALISBURY	**635 STATESVILLE BOULEVARD SALISBURY, NC 28144**

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F 607	Continued From page 33 Resident #16).	F 607		

Resident #16).

The Findings Included:

Review of the facility policy titled Abuse, Neglect and Exploitation, with a revised date of 10/22/20, revealed the following:
V. Investigation of Alleged Abuse, Neglect and Exploitation:
A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.
B. Written procedures for investigation include:
1. Identifying staff responsible for the investigation;
2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);
3. Investigating different types of alleged violations;
4. Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;
5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and
6. Providing complete and thorough documentation of the investigation.

A nursing progress note dated 9/18/20 and timed 2:36 PM by Nurse #1 documented it had been reported by Resident #16 that Resident #2 had hit him while they were both at the smoking area on 9/17/20.

A 24-hour report dated 9/18/20 revealed an allegation that specified Resident #2 had punched Resident #16 in the face while the two of

Provider's Plan of Correction (F 607):

10/30/20 by the administrator for the protection of others.

2.11/24/20 100% audit of alert and oriented was completed on abuse with no negative findings.

3. 11/05/2020 in-service was completed on with staff on abuse.

Audit alert and oriented residents weekly for 3 weeks and monthly for 3 Months Social Worker will bring to Qapi to discuss results.

4.Administrator is responsible for implementing the acceptable plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ACCORDIUS HEALTH AT SALISBURY	**635 STATESVILLE BOULEVARD** **SALISBURY, NC 28144**

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F 607	Continued From page 34	F 607		

them were in the smoking area on 9/17/20. The facility alleged they did not become aware of the altercation until 9/18/20 at 12:50 PM. The 24 hour report was signed by Administrator #1 on 9/18/20. The allegation type was classified as resident abuse and the local police department was documented as having been notified.

The facility ' s 5-working day investigation report dated 9/25/20 revealed the allegation of resident abuse when Resident #2 punched Resident #16 in the face on 9/17/20 was investigated, substantiated, and had caused harm to Resident #16, as evidenced by his lip being swollen. The report was signed by Administrator #1 on 9/25/20.

During an observation conducted on 10/27/20 at 4:10 PM a video camera was observed under the awning with the lens pointed toward the smoking area.

An observation of facility security camera footage from 9/17/20 and timed 3:33 PM was conducted in conjunction with an interview with the Maintenance Director (MD) and the Maintenance Assistant (MA) on 10/28/20 at 2:33 PM. The video showed the physical abuse between Residents #2 and #16 on 9/17/20. At the conclusion of the video the Maintenance Director stated he was the only one who had access to the facility video surveillance system, and he stated neither he nor anyone else had observed the just viewed video footage prior to that viewing.

During an interview with Resident #16 conducted on 10/29/20 at 2:46 PM he said no one from the facility had come to him to discuss the altercation he had with Resident #2.

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 11/17/2020

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ACCORDIUS HEALTH AT SALISBURY	**635 STATESVILLE BOULEVARD SALISBURY, NC 28144**

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F 607	Continued From page 35 During an interview with Administrator #1 conducted on 10/28/20 at 5:41 PM she stated she had not viewed the video footage from 9/17/20 between Resident #2 and Resident #16. On 11/06/20 at 2:36 PM during a phone interview with The Regional Director of Operations and Administrator #2, who replaced Administrator #1 on 11/2/20, it was stated by Administrator #2 it would have been reasonable to have viewed the available security camera footage of the smoking patio from 9/17/20 as part of the investigation to determine what occurred between Resident #2 and Resident #16.	F 607		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		11/27/20

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 11/17/2020

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(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 755

Continued From page 36

the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, Nurse Practitioner (NP), staff, and resident interviews, the facility failed to re-order morphine medication for a resident who had long-term use of morphine for pain management. The resident ' s last dose of morphine was on 10/25/20 during the 8:00 AM medication pass and the resident and the resident ' s Nurse Practitioner was not notified until 10/27/20 (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 12/4/19 with diagnoses which included: Limitation of activities due to disability, partial intestinal obstruction (which resulted in an abdominal hernia), and depression.

Review of the Minimum Data Set (MDS) assessment dated 9/15/20 revealed the following regarding Resident #2: He was cognitively intact; he was coded as having had pain for the past 5 days, received no as needed medications for pain, received no non-medication interventions for pain, had pain frequently, and he rated his pain at the highest level at 10 on a 0-10 scale.

F 755

F-755

Address how corrective action will be accomplished for those residents found to have been affected:

1. Resident #2s pain medication was audited to ensure that residents pain medications were ordered and available.
2. 100% of all current residents charts were audited with a cart to medication administration review per pharmacy consultant on 11/18/2020

Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice;

1. Current residents orders for pain medication will be reviewed during clinical morning meeting for accuracy and receiving of medications.

2.100% of pain medications will be accounted prior to clinical morning meeting to ensure all pain medication is

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F 755	Continued From page 37	F 755		

A review was completed of the medication monitoring control record (narcotics sheet) for Resident #2 ' s 30 milligram (mg) morphine sulfate tablets. The review revealed 30 morphine tables were received on one of two cards on 9/25/20; there were another 30 on a second card. The directions for the administration were one tablet orally every 12 hours for pain. The next available refill date was 10/20/20. Administration from the card was initiated on 10/10/20. The last dose give was by Medication Aide #1 on 10/25/20.

Review of the Medication Administration Record (MAR) for Resident #2 for the period of 10/1/20 through 10/29/20 revealed an order for Morphine Sulfate Extended Release Tablet, 30 mg, orally, every 12 hours for pain. Further review revealed the resident received the medication every 12 hours, at 8:00 AM and 8:00 PM, from 10/1/20 through the 8:00 AM dose on 10/25/20 at 8:00 AM. The following doses had a code for not being administered as other/see nurses notes, 10/25/20 at 8:00 PM, 10/26/20 at 8:00 AM, 10/27/20 at 8:00 AM, 10/27/20 at 8:00 PM, and 10/28/20 at 8:00 AM. There was one recorded dose as having been administered on 10/26/20 at 8:00 PM by MA #2. There was an order for oxycodone hydrochloride (HCl) extended release 12 hour, dated 10/27/20, 20 mg, one tablet by mouth every 12 hours for moderate to severe pain for 5 days, stop when morphine sulfate is delivered. The medication was documented as not administered on 10/27/20 with code for not being administered as other/see nurses notes and on 10/28/20 the resident was documented as having a pain level of 10 at the time of administration at 8:00 PM. The medication was discontinued on 10/28/20. On 10/29/20 there

available.

1a. Re-educate the clinical staff on ordering medication in timely manner and not prior to seven days to reordering pain medications
2. Licensed nurse will review omissions report at the end of each shift to identify omissions or missed medication and correct.

3. Director of Nursing/designee will review Point Click Care in clinical morning meeting to ensure no medication errors are noted.

Indicate how the facility plans to monitor its performance and maintain compliance:

1. Current resident□s medication will be audited per resident□s medication order to cart audit will be completed by the Pharmacy Consultant on 11/18/2020.
2. Medication review for compliance of administration for all residents will be reviewed for any omissions in clinical morning meeting five times per week for 3 weeks; 3x□s per week for 3 weeks and weekly times 3 weeks.
3. Results of audit will be reviewed monthly x 2 and results taken to qapi for review.

Director of Nursing is reasonable for implementing an acceptable plan of correction.

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F 755	Continued From page 38	F 755		

Continued From page 38

was a new entry for Morphine Sulfate tablet 30 mg, give one tablet orally every 12 hours for pain management. The medication was documented as having been administered at 8:00 AM on 10/29/20 and the resident had a pain level of 10 and at 8:00 PM on 10/29/20 and the resident had a pain level of 7. Further review did reveal the resident was additionally on oxycodone-acetaminophen tablet 10/325 mg ordered, dated 7/8/20, one tablet every 8 hours for chronic pain. Review of the MAR revealed the resident did receive the oxycodone (dated 7/8/20) as ordered and reported a pain level of 10 at 8:00 AM on 10/27/20 and 10/28/20.

During an interview with Resident #2 conducted on 10/27/20 at 12:14 PM stated he had not had his morphine medication in 4 days and had only had his oxycodone. The resident was unable to identify how long he had been on morphine for pain relief but stated it had been a long time, well before he was admitted to the facility. The resident stated he had experienced pain at the highest level, a 10 on a 0-10 scale, since he last had his morphine pain medication. The resident pointed an area on his stomach which protruded and stated he had a hernia which caused him pain and discomfort.

An interview was conducted with MA #2 on 10/28/20 at 11:13 AM. She stated the Nurse Practitioner (NP) #2 had ordered the oxycodone 20 mg abuse deterrent on 10/27/20 because Resident #2 continued to complain of pain and said that he hurt all of the time. The MA said she did not have any morphine in the cart for Resident #2 and that was why the oxycodone 20 mg abuse deterrent had been ordered.

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F 755	Continued From page 39 An interview was conducted on 10/28/20 at 11:33 AM with Nurse #2. During the interview the nurse stated the prescription for Resident #2 ' s morphine was sent to the pharmacy on 10/27/20. She said the resident was receiving his other pain medication, the oxycodone. The nurse reviewed the narcotics sheet for Resident #2 ' s morphine and stated the last dose of Resident #2 ' s morphine was administered on 10/25/20 and it was not re-ordered because a new prescription was needed, and they did not get the new prescription until 10/27/20. The nurse said the resident ' s morphine was supposed to come in from the pharmacy on the delivery expected the night of 10/28/20. A phone interview was conducted with NP #2 on 10/28/20 at 1:05 PM. The NP stated Resident #2 ' s morphine was on back order. The NP further stated it was his expectation for the morphine to have been ordered in advance so there would not be a lapse in administration. The NP said further adding to the problem with supplying the morphine for the resident was that the pharmacy had needed an actual prescription prior to sending the medication due to it being a narcotic. The NP stated it was not healthy for someone to abruptly stop taking morphine after having taken it for a long time. He said he did not know how long the resident had been taking the morphine but was pretty sure it was a long time. The NP stated Resident #2 had not received the prescribed morphine since 10/25/20 and he was "fairly miserable" by the time he had seen him on 10/27/20. The NP stated he had ordered the oxycodone 20 mg abuse deterrent medication to help the resident with his pain and discomfort until the morphine arrived.	F 755		

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F 755	Continued From page 40	F 755		

During an interview conducted on 10/29/20 at 3:14 PM with Nurse #1 she stated when Resident #1 was admitted in December of 2019 he arrived already having been on morphine.

During a phone interview with NP #1 on 10/30/20 at 12:13 PM she stated it was her expectation for the facility to call her for prescriptions and refills for medications prior to the medication running out. She further stated it did not matter if it was during the week or the weekend about calling for refills and prescriptions and she had also she had also experienced problems with the pharmacy supplying ordered medications in a timely manner.

Multiple attempts were made to interview MA #1, but all were unsuccessful.

During a phone interview with the facility Nurse Consultant (NC) conducted on 11/17/20 at 1:08 PM she stated typically the process for re-ordering medications was when the supply was down to seven days, the provider would be contacted to see if there was a need to refill the medication or what do next. The NC stated the morphine for Resident #2 was on back order from the pharmacy and the pharmacy had not communicated to the facility regarding the back order. The NC stated NP #2 had ordered the oxycodone 20 mg abuse deterrent because the resident ' s morphine had run out. The NC stated when the MAs or the nurses became aware the morphine had not arrived from the pharmacy and there was none left at the facility for the resident the resident ' s provider (NP or doctor) should have been contacted to obtain an order to hold the medicine or to receive an order for another medication to be used in its place.

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F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to ensure that resident identification was conducted by a contracted laboratory services technician to prevent blood from being drawn from the resident in error for 1 of 1 residents reviewed for laboratory services (Resident #5). Findings included: Resident #5 was admitted to the facility on 07/29/19 with diagnoses including; chronic atrial fibrillation, heart failure, chronic pain and a history of falls. A quarterly Minimum Data Set assessment completed on 08/18/20 noted Resident #5 was cognitively intact. Review of the Grievance Log from February 2020 indicated a complaint related to blood work for Resident #5 filed by the Resident's Responsible Party (RP). The grievance noted that the resident refused to have her ordered bloodwork done on 02/07/20, as she stated she did not want to have the same technician draw blood when this technician had not properly identified her	F 770	Address how corrective action will be accomplished for those residents found to have been affected: 1. Resident #5 lab tracking was audited and resolved on 01/29/20 with notification with lab company and review of lab orders. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice; 1. The Director of Nursing Completed an Audit of Current Residents lab orders and matched with results received from lab no other resident noted to be affected. 2. The Director of Nursing and Social Worker conducted Interviews with Residents to ensure labs are Drawn and Technician identifies themselves. Address what measures will be put into place, or systemic changes to ensure that the deficient practice will not occur:	11/27/20

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F 770	Continued From page 42 previously. Due to Resident #5's identification not being confirmed, the lab technician had drawn blood work in error on 01/29/20. The grievance was resolved when the contracted service switched the lab personnel that were sent to the facility. An interview with Resident #5 on 10/28/20 at 4:38 PM regarding the lab work drawn several months ago without confirmation of her identity. Resident #5 stated she did not recall the incident 8 months ago, when a lab technician failed to correctly identify her and mistakenly drew her blood. She stated she had lab work done frequently. On 10/29/20 at 4:45 PM an interview with the Nurse Manager that handled the grievance. She stated the incident that concerned the incorrect blood draw had been reviewed. She said they realized the incorrect lab draw immediately and they called Resident #5's RP. They also notified the Supervisor at the contracted laboratory company. The Nurse Manager said the RP later called back and had spoken with the former Director of Nursing regarding the incident. The manager from the contracted Laboratory service was interviewed on 11/02/20 at 10:42 AM regarding the incorrect blood draw on Resident #5. She stated the incident was reviewed, the staff member was counseled and was not permitted to return to the facility. She stated the reassignment occurred on 02/21/20, and they had taken this issue very seriously, educated staff and conducted follow up. She stated the staff member no longer worked for the company. An interview was completed with the Director of Nursing on 11/29/20 at 2:40 PM. She said that	F 770	1. Re-educate the clinical staff on proper identification of residents receiving lab draws on the date ordered by discussing with laboratory technician prior to lab draws. 2. Licensed nurse will review what lab draws are to be done for that day and face sheets in lab book identifies residents with pictures. 3.Lab tech will ask staff if unable to identify resident by face sheet. Indicate how the facility plans to monitor its performance and maintain compliance. 1. labs will be review for compliance for all residents in clinical morning meeting five times per week for 3 weeks; 3x per week for 3 weeks and weekly times 3 weeks. monthly for 2 months. Results of audit will be reviewed by QAPI committee. Director of Nursing is responsible for implementing the acceptable plan of correction	

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F 770	Continued From page 43 proper identification of the resident's for lab work was important and the technician was supposed to confirm the correct resident's blood was being drawn. When questioned regarding the incident with Resident #5 she stated the technician was counseled and was told she would not return to the facility. An interview was conducted with the Administrator on 10/30/20 at 10:45 AM regarding the failure to ensure proper identification of residents with lab work draws. She stated that if the resident was alert and oriented the lab technician would ask their name, and if they were not alert and oriented, they would get staff to ensure it was the correct resident. She was not aware of any incidents when labs were drawn on a resident that should not have been. She noted that if that occurred, they would call the contracted company and do an incident report.	F 770		