PRINTED: 03/02/2021
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
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	**115 N COUNTRY CLUB ROAD BREVARD, NC 28712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey and complaint investigation were conducted on 01/28/21 with exit from the faciity on 01/28/21. Additional information was obtained through 02/05/21; therefore, the exit date was changed to 02/05/21. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 910H11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 01/28/21. Additional information was obtained through 02/05/21; therefore, the exit date was changed to 02/05/21. 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. Three of the nine complaint allegations were substantiated resulting in deficiencies. Event ID# 910H11.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		3/5/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/01/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, family and	F 580	* Corrective action for those affected by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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

F 580 Continued From page 2

physician interviews the facility failed to notify the Responsible Party (RP) and physician of a decline in a resident's level of consciousness and mental status (Resident #1) and failed to notify the RP of laboratory and x-ray results (Resident #3) for 2 of 5 residents reviewed for notification.

The findings included:

1. Resident # 1 was admitted to the facility 05/31/20 with diagnoses of non-Hodgkin's lymphoma (cancer of the disease-fighting network throughout the body), dementia, and bi-polar disorder.

The Care Plan for Resident #1, revised on 07/29/20, identified a mood problem related to disease processes which included non-Hodgkin's lymphoma and bipolar disorder. Interventions included administer medications as ordered; monitor, record, and report to the Medical Doctor (MD) as needed a change in appetite, eating, sleep patterns, a diminished ability to concentrate and change in psychomotor skills.

A significant change in status Minimum Data Set dated 11/09/20 assessed Resident #1 as having severely impaired cognition with unclear speech with the ability to sometimes understand and be understood. Resident #1 required extensive assistance with bed mobility, transfers, eating, and toilet use. The Care Area Assessment described a potential for altered communication related to impaired cognition and aphasia (poor comprehension and difficulty forming words) with unclear speech.

A review of a progress note written on 12/20/20 at 10:37 PM revealed Nurse #1 held the night time

F 580 (Plan of Correction)

the alleged deficient practics cannot be achieved as resident #'s 1 and 3 have expired.
* In order to identify other residents that may have been affected by this same alleged deficient practice, the Medical Records clerk (MRC) performed an audit of all active medical records checking to ensure that all necessary communications to RPs as noted in F 580 were performed and documented. The MRC has been and continues to check change of condition, changes that alter treatment significantly, decision to transfer or discharge the resident, or change in roommate. Any instances identified through this audit will be noted and communicated to the Administrator and/or Dir of Nursing (DON) so that appropriate communication can be achieved. this audit will be completed by 3-4-21.
* Measures and systematic changes put into place to achieve compliance include: 1) The DON and MDS nurses will inservice all licenses nurses on the importance of communicating the above noted instances to the Responsible Parties of the residents. All nurses will be educated by 3-4-21 either in person or via telephone. Nurses that are on vacation or leave will be educated prior to working. This education will be part of orientation for new nurses as well as agency nurses. 2) A Checklist/Monitor will be implemented in which the nurses log any of the above noted changes in condition including info regarding Responsible Party notification. This checklist/monitor will be reviewed daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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

F 580 Continued From page 3

medications due to Resident #1 being unable to open her mouth and take. The progress note revealed Resident #1 was able to move upper extremities when touched but had no verbal response. Nurse #1 documented she would inform the MD via a written report. There were no other nurse progress notes written from 12/20/20 at 10:37 PM through 12/21/20 at 5:30 PM.

A change in condition note written by Nurse #1 on 12/21/20 at 5:30 PM revealed a Situation-Background-Assessment-Recommendation (SBAR) describing Resident #1 as being somnolent (excessive drowsiness) and not taking oral medications. The recommendation from the on-call Nurse Practitioner (NP) was send to the emergency room for evaluation for a new onset of a change in condition. The note included documentation the Responsible Party (RP) had been notified.

A review of the physical examination from the Emergency Room (ER) report dated 12/21/20 described Resident #1 as being unresponsive and nonverbal with flaccid paralysis of the right upper and lower extremities and right-sided facial droop. The ER assessment identified these symptoms as being an acute stroke with a history of brain cancer.

During an interview on 02/02/21 at 2:09 PM Nurse #1 confirmed on 12/20/20 she was unable to administer Resident #1's night time medications. Nurse #1 described Resident #1 wouldn't open her eyes or mouth. Based on her assessment Nurse #1 determined the symptoms were an expected progression of Resident #1's brain cancer and decided not to call and notify the on-call physician instead wrote a communication

F 580

(M-F) by the DON/MDS nurses for completion. 3) Also daily, (Mon-Fri), during the morning meeting, the MDS nurse will review any noted changes with residents identified from the day prior (or days prior if the weekend)and new orders. During the meeting, the Electronic medical Record (EMR) will be reviewed to ensure that proper notification has been achieved and documented. This will be done by the MDS nurse/Administrator starting 3-1-21. 4) Missed communication will be addressed by the DON or MDS nurses following the meeting.
* The results of the checklist/monitor will be presented by the DON/MDS nurses to the Quality Assurance Performance Improvement (QAPI) committee starting in March and will then be presented monthly for a period of 3 months or longer as needed. The QAPI may suggest adjustments to the monitor or plan to ensure compliance.
* completion date 3-5-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	**115 N COUNTRY CLUB ROAD BREVARD, NC 28712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 note for MD to see Resident #1 the following day. Nurse #1 didn't notify the RP and explained Resident #1's cancer treatments were discontinued, and it was her understanding the RP was aware there would be changes. During an interview on 02/03/21 at 12:23 PM the facility MD explained based on the progress note written on 12/20/20 at 10:37 PM he expected Nurse #1 to call the on-call physician to report Resident #1 wouldn't open her eyes or take medication. The MD explained a written communication note to see Resident #1 wasn't a sufficient response by Nurse #1. During a phone interview on 02/04/21 at 3:18 PM the RP explained during a scheduled window visit on 12/21/20 Resident #1 was slumped over in a fetal position with her head down while sitting in a wheelchair and did not respond to him or the nurse. The RP didn't understand why he or the MD hadn't been notified before his visit. An interview was conducted with Administrator and Director of Nursing (DON) on 02/05/21 at 1:48 PM. The DON explained Nurse #1 was aware of the brain tumor diagnosis and Resident #1's trajectory was for a decline and she wasn't going to improve. The Administrator and DON thought Nurse #1's response to monitor without notification to the MD on 12/20/20 was appropriate. The Administrator and DON explained on 12/21/20 the nurses were aware Resident #1's RP was scheduled for a window visit and would see how she had changed and could decide how to proceed with care. The DON and Administrator agreed the nurse responded and did what was appropriate by waiting for the RP's visit then notify the on-call NP, so a decision	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	**115 N COUNTRY CLUB ROAD BREVARD, NC 28712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 could be made on how to proceed with Resident #1's care. 2. Resident #3 was admitted to the facility on 10/06/20 with diagnoses that included syncope (temporary loss of consciousness) and collapse, diabetes, acute kidney failure, and chronic kidney disease. The admission Minimum Data Set (MDS) dated 10/12/20 noted Resident #3 had intact cognition and required extensive staff assistance with most activities of daily living. Further review revealed she received oxygen therapy 5 of 7 days during the MDS assessment period. Review of Resident #3's medical record revealed the following physician orders: 10/19/20 read, Sputum (mucus coughed up from the respiratory tract) Gram Stain (laboratory test used to detect bacteria in a sputum sample) one time only for possible infection. 10/23/20 read, 2-view chest x-ray one time only for congestion. The Sputum Gram Strain test results dated 10/23/20 for Resident #3 revealed a "heavy growth of Escherichia Coli (bacteria)" and Methicillin Resistant Staphylococcus Aureus (specific bacteria). An undated handwritten note by Nurse #4 read in part, "order chest x-ray. Keep monitoring resident and if wheezing occurs, notify the physician." The chest x-ray results dated 10/23/20 and faxed to the facility on 02/02/21 for Resident #3 revealed no pneumothorax (collapsed lung), no pleural effusion (buildup of fluid between the layers of tissue that line the lungs and chest	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	**115 N COUNTRY CLUB ROAD BREVARD, NC 28712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 cavity) and no acute cardiopulmonary process (sudden effect on heart or lung function). Review of Resident #3's staff progress notes for October 2020 revealed no entry indicating the Responsible Party (RP) was notified of the laboratory test results and subsequent order for a chest x-ray received on 10/23/20. Resident #3 passed away at the facility on 10/24/20. During a telephone interview on 02/02/21 at 11:27 AM, Resident #3's RP reported he was unaware a chest x-ray was ordered for Resident #3 until he received a statement from the insurance company and was never notified of the test results. During a telephone interview on 02/03/21 at 3:40 PM, the Administrator confirmed the staff initials on Resident #3's laboratory test results dated 10/23/20 were Nurse #4's. The Administrator explained Resident #3 passed away on 10/24/20 and she was not sure if the results of the chest x-ray for Resident #3 were ever received by the facility. The Administrator added she contacted the x-ray company on 02/02/21 to obtain a copy of Resident #3's chest x-ray results from 10/23/20. During a telephone interview on 02/04/21 at 8:23 AM, Nurse #4 was unable to recall receiving the laboratory test results for Resident #3 on 10/23/20 or which physician she contacted who gave the order for the chest x-ray. Nurse #4 explained when test results were received, she notified the physician and followed any orders, notified the resident's RP and entered a progress	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 note into the resident's medical record. Nurse #4 could not remember if she had notified Resident #3's RP on 10/23/20 when the order for the chest x-ray was obtained by the physician and stated she could not explain why a progress note was not entered in Resident #3's medical record if she signed off on the test results. A joint telephone interview was conducted with the Administrator and Director of Nursing (DON) on 02/04/21 at 3:40 PM. The Administrator and DON both agreed due to Resident #3's passing on 10/24/20, follow-up on the chest x-ray results obtained 10/23/20 had been overlooked. The DON stated Nurse #4 should have notified Resident #3's RP of the laboratory test results and physician's order for a chest x-ray when both were received on 10/23/20.	F 580		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews the facility failed to prevent a significant medication error by not transcribing an order from a discharge summary and failing to administer 14 doses of an antibiotic prescribed for a Urinary Tract Infection (UTI) for 1 of 1 resident reviewed for medication errors (Resident #2). The findings included:	F 760	* Corrective action for Resident #2 as this resident has since expired. * A review of the discharge instructions for residents going to outside medical appointments or to the Emergency Room in Februray was conducted to ensure that any new medications were entered into the Electronic Medical Record(EMR)correctly. Review completed by the Medical Records Clerk (MRC)by 3-2-21. Any errors identified were corrected with the Physician and	3/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 760

Continued From page 8

Resident #2 was admitted to the facility on 09/13/10 with diagnoses which included dementia, chronic pain, and a communication deficit.

A review of Resident #2's Emergency Room (ER) discharge instructions dated 12/30/20 under the section titled, "Medications: New Medications to be taken at Home," revealed cefadroxil (an antibiotic medication) 500 milligrams (mg) give 1 capsule oral every twelve hours for 7 days to treat or prevent infection.

A review of a progress note written on 12/31/20 documented the return of Resident #2 from the hospital on the previous shift with no new orders.

The corrected comprehensive Minimum Data Set dated 12/31/20 assessed Resident #2's cognition as being severely impaired. Resident #2 required extensive assistance for toilet use and was always incontinent of bladder and bowel. The Care Area Assessment for urinary incontinence described Resident #2 was generally debilitated and needed assistance with toileting and personal hygiene and was frequently incontinent and at risk for UTI's.

A review of the Care Plan revised on 01/13/21 for Resident #2 identified bowel and bladder incontinence related to impaired mobility and dementia with the goal to prevent and minimize the risk for septicemia by prompt recognition and treatment of symptoms of a UTI. Interventions included monitor and document for signs and

F 760 (Plan of Correction)

Responsible party being notified by the Director of Nursing (DON).
* Measures put into place to prevent this same alleged deficient practice from recurring include: 1) All licensed nurses will be inserviced on the significance of this citation and how discharge instructions are to be handled. The DON is providing the inservice education. All nurses will be inserviced by 3-5-21. New nurses will be educated about this process during orientation as will agency nurses. 2) Discharge instructions from outside appointments/ER are to be reviewed by the Charge Nurse as well as the DON upon receipt. 3) New orders are to be entered into the EMR by the Charge Nurse immediately. 4) DON will receive a copy of the discharge instructions and these will be reviewed daily (M-F) in the morning meeting. In the meeting any new orders will be checked in the EMR for accuracy (DON/MDS nurse). 5) A monitor listing residents with outside appointments/ER visits will be started which reflects any new orders starting 3-1-21. This monitor will be used in the morning meetings to verify that no new orders were missed. This monitor will be maintained and completed by the DON/MDS nurses.
* The results of the monitor will be presented by the DON in the monthly Quality Assurance Performance Improvement (QAPI) meeting starting in March. The QAPI team may make suggestions to adjust this plan/monitor in order to acheive compliance. The results of this monitor will be reviewed for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 760	Continued From page 9	F 760		

symptoms of UTI such as: pain, burning, urinary frequency, foul smelling urine, fever, and altered mental status.

A review of the December 2020 and January 2021 Medication Administration Record (MAR) revealed cefadroxil had not been transcribed on either of Resident #2's MARs.

A phone interview was conducted with Nurse #3 on 02/04/21 at 1:44 PM. Nurse #3 explained any new order received was transcribed into the computer to ensure it appeared on the MAR. Nurse #3 confirmed she received and reviewed the ER discharge instructions and received a verbal report from the hospital nurse when Resident #2 returned to the facility on 12/30/20. Nurse #3 didn't recall any new orders or Resident #2 being diagnosed with a UTI but did recall placing the discharge instructions in a folder for medical records to place in the resident's chart.

A phone interview was conducted with Director of Nursing (DON) on 02/04/21 at 4:42 PM. The DON confirmed a physician's order was written on the ER discharge instructions of Resident #2 for cefadroxil dated 12/30/20. The physician order was not transcribed on the December 2020 or January 2021 MAR to show cefadroxil was given. The DON explained the receiving nurse would be the one to review the discharge instructions and transcribe new orders to the computer which would appear on MAR to be given. The DON expected Nurse #3 to transcribe cefadroxil to the MAR and administer the medication per physician orders.

period of at least 3 months by the QAPI team.
* Completion date 3-5-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	**115 N COUNTRY CLUB ROAD BREVARD, NC 28712**

(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 760	Continued From page 10 A phone interview was conducted with Medical Doctor (MD) on 02/05/21 at 11:29 AM. The MD explained if the ER physician ordered antibiotics the physician must have felt Resident #2 needed the medication. The MD expected medications to be given as ordered and considered 14 missed doses of cefadroxil or an antibiotic to be a significant medication error. Since Resident #2's discharged from the ER the MD had seen the resident and explained no harm occurred from the missed antibiotic doses. The MD explained Resident #2 could continue to have bacterial colonization of the bladder but since discharge form the ER there have been no other symptoms of a UTI.	F 760		