STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	C 01/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 01/26/21 through 01/29/21 Event ID# DFOY11. 8 of the 18 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		2/22/21

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

Electronically Signed | 02/18/2021

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F 623	Continued From page 1	F 623		

be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 2 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notification to the regional ombudsman of facility-initiated resident transfers and discharge for 3 of 3 months (10/2020, 11/2020 and 12/2020) reviewed. The findings included: On 01/27/2021 at 1:03 PM, an interview was conducted with the Ombudsman. The Ombudsman stated she had not received a monthly list of resident transfer and discharge notices from the facility for the months of	F 623	On 1/27/21 the transfers and discharges for the months of 10/2020, 11/2020 and 12/2020 were sent to the Ombudsman via email. The Ombudsman did receive the email. On 1/27/21 the Social Worker was re-educated by the Administrator on 1/27/21 regarding sending the transfer/discharge information to the Ombudsman at the end of every month as requested. A calendar request was sent to the Social Worker's email on 2/17/21 to	

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F 623	Continued From page 3 10/2020, 11/2020 and 12/2020. The Ombudsman stated she had responded to an email in 07/2020 from the facility's Social Worker (SW) asking if the discharge notices still needed to be sent, which the ombudsman had replied to the affirmative. The Ombudsman stated the last monthly notice of facility-initiated transfers and discharges that she had received from the facility was from 09/2020. On 01/27/2021 at 9:31 AM, an interview was conducted with the Social Worker (SW). The SW stated she normally sent an email with resident transfers and discharges to the ombudsman at the end of the month. The SW stated she sent an email on 09/30/2020, with resident discharges for the month of September. The SW could not find an email with the monthly resident discharge list that was sent to the Ombudsman for 10/2020, 11/2020 or 12/2020. The SW stated she knew for sure she had not sent a notice for 11/2020 because she was on sick leave at the end of November 2020. The SW stated she could not find emails that were sent to the Ombudsman with the discharge notices for the three months in question. On 01/27/2021 at 3:48 PM, an interview was conducted with the Administrator. The Administrator stated she expected the SW to send monthly resident transfer and discharge notices to the Ombudsman in a timely manner.	F 623	remind her every month. The Administrator will audit monthly for 3 months to ensure the Social Worker is sending transfers/discharges to the Ombudsman. The transfers/discharge report and the sending to the Ombudsman will be reviewed during the monthly Quality Assurance Performance Improvement meeting monthly for 3 months. Negative findings will be addressed. Additional interventions will be implemented to ensure sustained compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		2/22/21

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F 656	Continued From page 4	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 5 Based on record review, observations, staff and resident interviews, the facility failed to develop a resident centered care plan for a resident with an indwelling catheter for 1 of 3 residents (Resident # 5) with a urinary catheter. The findings included: Resident # 5 was admitted to the facility on 9/17/2020 with diagnoses that included neuromuscular dysfunction of the bladder, disorder of the urinary system, and quadriplegia . Review of the admission minimum data set (MDS) assessment dated 9/23/2020 revealed Resident # 5 was cognitively intact. She required extensive one-person assistance for toileting and personal hygiene. Resident #5 had an indwelling catheter . A review of the care area assessment dated 9/23/2020 revealed that the facility identified triggered care areas for urinary incontinence and indwelling catheter. The CAA worksheet indicated urinary incontinence and indwelling catheter would be addressed on the care plan. A review of resident #5's care plan initiated on 9/17/2020 did not reveal the resident was care planned for an indwelling catheter. A review of the quarterly MDS assessment dated 12/22/2020 revealed Resident #5 had an indwelling catheter. A review of Resident #5's physician order report for January 2020 revealed an order for an indwelling catheter to be changed every 30 days.	F 656	Resident affected by the deficient practice: The care plan for resident #5 was updated by the Interdisciplinary Team on 1/28/21. Other residents with indwelling catheters are at risk for the same deficient practice: Walking rounds were made by the Director of Nursing/designee to identify current residents with indwelling catheters on 2/1/21. The current residents who were identified with indwelling catheters had their care plan reviewed and updated by the Director of Nursing/designee to reveal a person-centered care plan. Systemic measures implemented to sustain compliance: The Interdisciplinary Team (IDT) were re-educated regarding comprehensive person-centered care plans on 2/18/21 by the interim MDS Coordinator, Director of Nursing/designee. During the morning clinical meeting Monday thru Friday the clinical dashboard will be reviewed by the Director of Nursing/designee to check new orders for indwelling catheters. When orders for indwelling catheters are noted the care plan will be reviewed and updated as needed by the Director of Nursing, MDS Coordinator/designee. Audits of 2 care plans weekly with residents with catheters will be completed by the Director of Nursing/designee will be completed X4 weeks and monthly X2 months. Negative findings will be addressed if noted. Monitoring: The results of the audits will be reviewed monthly X3 months during the facility Quality Assurance Performance	

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F 656	Continued From page 6 An observation of Resident # 5 on 1/27/2021 at 2:04 pm revealed the resident had an indwelling catheter. An interview was conducted with Resident # 5 on 1/27/2021 at 2:04 PM. Resident #5 revealed she had an indwelling catheter when admitted to the facility. An interview was conducted with the Director of Nursing (DON) on 1/29/2021 at 3:32 PM. The DON stated she expected that the staff nurses would update the resident's care plan. The DON stated the MDS Coordinator was responsible for updating the care plans prior to her leaving. The DON stated she expected that the staff nurses would update the resident's care plan while the facility did not have a MDS coordinator. The DON stated the nursing had not been trained and would need education to update resident care plans.	F 656	Improvement (QAPI) meeting by the QAPI committee. Negative findings will be addressed by the committee if noted. Additional interventions will be developed and implemented by the committee to ensure sustained compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		2/22/21

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F 657	Continued From page 7 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan in the areas of weight loss and pressure ulcers for 2 of 3 sampled residents (Resident #1 and Resident #5) reviewed for nutritional status and pressure ulcers. The findings included: 1. Resident # 1 was admitted to the facility on 07/02/2020 with diagnoses to include history of motor vehicle accident, traumatic brain injury, subarachnoid hemorrhage, pressure ulcer of sacrum, osteomyelitis, and dysphagia. Resident #1's admission weight was recorded in the medical record as 128 pounds. Resident #1's admission Minimum Data Set (MDS) assessment, dated 07/08/2020 revealed resident #1 had severe cognitive impairment. He required extensive 2-person assistance with bed mobility and dressing, and extensive one-person assistance with eating, toilet use, and personal	F 657	Resident #1 was discharged from the facility on 1/13/21 Resident #5 had a care plan review on 2/17/21 and the care plan was updated to reveal the status of the resident's wound and nutritional status. Current Residents with wounds and/or weight changes are at risk for the same deficient practice: Current wound report provided by wound vendor on 2/11/21. Care plans were reviewed and updated as needed to reflect the resident's status. Weights of current residents were obtained by 1 Certified Nursing Assistant on 2/9/21 to identify any weight loss/gain. Registered Dietician was provided a wound and weight report by the Director of Nursing on 2/9/21. Registered Dietician recommendations were provided to the physician for approval on 2/18/21. Orders will be input by the Director of Nursing (DON)/designee as approved. Care plans	

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F 657	Continued From page 8 hygiene. The resident was admitted with one stage 4 pressure ulcer. A review of Resident #1's care plan dated 07/14/2020 included a focus of a risk for nutritional deficit related to dysphagia. Interventions included to monitor/document and report any signs and symptoms of dysphagia, and monitor/record/report to the physician signs of malnutrition, significant weight loss. On 09/24/2020 the resident's weight was recorded as 126 lbs. The resident was discharged to the hospital on 10/04/2020 and re-admitted on 10/20/2020. There was no readmission weight documented in the resident's medical record. Resident #1's care plan, dated 11/01/2020 included a focus of a risk for nutritional decline and/or weight loss due to receiving 100% of nutrition via gastrostomy (feeding) tube. Interventions included to monitor/evaluate weight and weight changes per facility protocol. The resident's care plan did not address that the resident experienced an actual weight loss. Review of the resident's weight record revealed the following weights: On 11/4/2020 the weight was 100.2 pounds. This weight reflected a weight loss of 25.8 pounds since the resident's prior weight was obtained on 09/24/2020. On 12/30/2020 the weight was 100.0 pounds. On 01/07/2021 the weight was 101.0 pounds.	F 657	will be updated by the DON/IDT on 2/18/21. Systemic measures implemented to ensure sustained compliance: The Interdisciplinary team (IDT) were re-educated regarding care plan updates by interim MDS Coordinator, DON/designee on 2/18/21. Physician orders will be reviewed by the Director of Nursing/designee daily Monday thru Friday to monitor for new, worsened or improved wound orders in addition to dietary/nutritional recommendations. Care plans will be updated by the DON/designee as needed to reflect a person-centered care plan. The IDT will audit 2 care plans of residents with wounds and/or weight loss weekly X4 weeks and monthly X2 months to ensure accuracy. Negative findings will be addressed if noted. Monitoring The results of the audits will be reviewed monthly X3 months during the facility Quality Assurance Performance Improvement (QAPI) meeting by the QAPI committee. Negative findings will be addressed by the committee if noted. Additional interventions will be developed and implemented by the committee to ensure sustained compliance.	

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On 01/29/2021 at 12:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she started at the facility around the time of Resident #1's readmission to the facility of 10/20/2020. The DON stated the MDS nurse had been updating the care plans, prior to her leaving the facility. The DON stated it did not occur to her that no one was updating the care plans because she thought the floor nurses were doing it. The DON stated resident care plans had not been updated which included Resident #1's care plan that did not address his actual weight loss.

2. Resident # 5 was admitted to the facility on 9/17/2020 with diagnoses that included injury at the C5 level of the spinal column, quadriplegia, and polyneuropathy.

Review of the admission minimum data set (MDS) assessment dated 9/23/2020 revealed Resident #5 was at risk for developing pressure ulcers. She had no open areas to skin.

The care area assessment (CAA) dated 9/23/2020 revealed that the facility identified triggered care area for pressure ulcer
.
Review of a nurse progress note dated 12/16/2020 revealed Resident # 5 had reddened area to her sacrum and treatment was completed.

A review of the quarterly MDS assessment dated 12/22/2020 revealed Resident # 5 had no open areas to skin.

A review of Resident #5's care plan most recently

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updated on 12/30/2020 did not reveal a care plan for pressure ulcers.

Review of a nurse progress note dated 1/20/2021 revealed the physician saw Resident # 5 for open area to right back bra line.

A review of the physician's orders dated 1/22/2021 revealed in part "sacrum- Clean with Dakins ¼ Strength. Pat dry. Apply silver alginate to wound bed and cover with dressing. Right lateral torso-cleanse with wound cleanser. Pat dry. Apply silver alginate to wound bed cover with dressing.

An interview was conducted with Resident #5 on 1/27/2020 at 2:04 PM. Resident # 5 revealed she currently had a wound to her sacrum and right side where her bra band had been pressing.

An interview was conducted with Nurse #1 on 1/27/2020 at 2:26 PM. Nurse #1 stated Resident #5 had two pressure ulcers that were cared for by the wound care nurse twice weekly. The nurse stated that the staff nurse cared for the wounds on other days according to the physician care orders. Nurse #1 stated that the management team updated the care plan during the morning meeting.

An interview was conducted with the Director of Nursing (DON) on 1/29/2021 at 3:32 PM. The DON stated she expected that the staff nurses would update the resident's care plan. The DON stated the MDS Coordinator was responsible for updating the care plans prior to her leaving. The DON stated she expected that the staff nurses would update the resident's care plan while the facility did not have a MDS coordinator. The DON

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F 657	Continued From page 11 stated the nursing had not been trained and would need education to update resident care plans.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to conduct weekly wound assessments with location, size, and description for 1 of 3 residents (Resident #1) reviewed for pressure ulcers. The findings included: Resident # 1 was admitted to the facility on 07/02/2020 with diagnoses to include history of motor vehicle accident, traumatic brain injury, subarachnoid hemorrhage, pressure ulcer of the sacrum, osteomyelitis, and dysphagia. Resident #1's admission Minimum Data Set (MDS) assessment, dated 07/08/2020 revealed	F 686	Resident #1 was discharged from the facility on 1/13/21. Current residents with wounds are at risk for the same deficient practice: Current residents with wounds were seen by the wound vendor on 2/11/21. Wounds were measured and described to include location. Residents with wounds will have weekly rounds with the wound vendor to assess skin for new, improved or resolved wounds and to measure all existing wounds to include the size, location, and a description of the wound. The Director of Nursing, Treatment Nurse/designee will transcribe the measurements onto the	2/22/21

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F 686	Continued From page 12 Resident #1 had severe cognitive impairment. He required extensive 2-person assistance with bed mobility and dressing, and extensive one-person assistance with eating, toilet use, and personal hygiene. The resident was admitted with one stage 4 pressure ulcer. A review of Resident #1's care plan dated 07/14/2020 included a focus of a stage IV pressure wound to the sacrum and was at risk for complications related to the wound and additional breakdown. Interventions included to administer treatments as ordered and do weekly treatment documentation to include measurements of each area of skin breakdown with width, length, depth, type of tissue and exudate. According to wound observation documentation, initially the resident's sacral wound was measured on 07/03/2020 and documented to be 9 centimeters (cm) long by 5 cm wide by .25 cm deep. Following the admission assessment, sacral wound observations with measurements were kept for the following dates: 07/20/2020 (which indicated 17 days between wound assessments) 08/03/2020 (which indicated 14 days between wound assessments) 08/17/2020 (which indicated 14 days between wound assessments) 08/28/2020 (which indicated 11 days between wound assessments) 08/31/2020 09/11/2020 (which indicated 11 days between wound assessments) 09/14/2020 09/28/2020 (which indicated 14 days between	F 686	pressure ulcer or non-pressure ulcer UDA weekly. Systemic Measures: Licensed staff will be educated on the "skin quick view" by the Director of Nursing/designee by 2/21/21. During the clinical meeting Monday thru Friday weekly skin check universal data access sheet (UDA) and the UDA related to pressure and non-pressure ulcers will be audited to ensure they have been completed timely. Negative findings will be address when/if noted. Results of the audits will be reviewed weekly with the Interdisciplinary Team X4 weeks and monthly X2 months. Monitoring: Results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement meeting X3 months. Additional interventions will be developed and implemented as deemed necessary by the committee to sustain substantial compliance.	

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F 686	Continued From page 13	F 686		

wound assessments).

According the medical record, on 10/04/2020 Resident #1 was discharged to the hospital. Prior to his hospital transfer, documentation regarding the sacral wound, dated 09/28/2020, noted the resident's wound measured 7 cm by 5 cm by .1 cm. This indicated the wound was improving when compared to his admission measurements of the wound on 07/03/2020.

According to the medical record, Resident #1 was re-admitted to the facility on 10/20/2020.

Resident #1's wound assessment on 10/21/2020, after returning to the facility from the hospital revealed the sacral wound was described as worsening and was measured at 10 cm length by 9 cm wide, by .2 cm deep; with tunneling from 12 o'clock to 2 o'clock. There were two other wounds documented on this date in addition to the sacral wound. A left hip wound was measured at 3 cm long by 3 cm wide, with no stage included, but described as a "blister-open". A right hip wound measurement was 3 cm long by 3 cm wide, not staged, but described as dry and no drainage.

A wound assessment dated 10/23/2020 revealed the presence of six wounds: sacrum, left hip, left heel, left ankle, left proximal ankle, and left distal ankle.

The next wound assessment occurred 12 days after 10/23/2020 and was dated 11/4/2020. This assessment documented the measurements of the sacral wound only.

Following 11/4/2020, the next wound assessment was on 11/06/2020. This wound assessment

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documented the measurements of the sacral and left ischium only.

Following 11/6/2020, the next wound assessment was on 11/09/2020. This wound assessment documented 5 wounds: sacrum, left hip, right hip, left heel and left ankle.

Following 11/09/2020, the next wound assessment was 10 days later on 11/19/2020. This wound assessment recorded measurements for the following: sacrum improving and measurements of 6.1 by 8.2 by 0.7 cm. The left outer ankle was 1 cm by 1.5 cm by 0.1 cm with 100 % slough. The left hip was 100% scab measured at 2.3 cm by 2.4 cm. The right hip was measured at 2.7 cm by 1.3 cm by 0.1 cm at stage 3 and worsening.

Following 11/19/2020, the next wound assessment was on 11/23/2020. This wound assessment included measurements for three wounds: the sacrum, left hip, and right hip.

Following 11/23/2020 the next wound assessment was on 12/14/2020, and included measurements for four wounds: the sacrum, left hip, right hip, and left ankle.

On 12/17/2020 weekly through 01/07/2021 measurements were documented, and wounds were staged by the wound consultation nurse practitioner (NP). The NP measured the sacrum, right hip, left hip and left ankle on 12/17/2020, 12/24/2020, and 12/31/2020. On 01/07/2020, the NP also measured a new wound on right upper arm. The progress of all the wounds on 12/31/2020 were documented as improving.

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A review of Resident #1's Treatment Administration Records (TAR) for 07/2020 through 01/2021 revealed treatment was conducted for all the resident's pressure wounds for all but 7 days out of the 7 months reviewed.

According to the record, Resident #1 was discharged to the hospital on 01/13/2021.

On 01/28/2021 at 10:01 AM, an interview was conducted with the wound nurse (WN). The WN stated she worked at the facility for 2 days per week. The WN stated she conducted wound measurements on Mondays when she was in the facility. The WN stated the floor nurses were responsible to change the dressing when the WN was not in the facility. The WN stated the physician looked at the wounds when he was in the facility on Wednesdays, but he did not have time to measure the wounds. The wound nurse stated a wound consulting company was addressing and documenting on the wounds at the present. The WN stated she did not know why the wounds had not been measured consistently. The WN stated she could not recall why some of the observations included measurements and others did not. The WN stated the sacral wound was getting better prior to the resident's hospital stay; and after the stay the wounds differed in their course of improvement and decline.

On 01/27/2021 at 12:39 PM, an interview was conducted with the Physician. The Physician stated he saw Resident #1's wounds every week, although he did not document the measurements. The Physician stated the sacral wound was improving prior to his hospitalization of 10/2020. The Physician stated after the resident contracted

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F 686	Continued From page 16 the COVID virus in 11/2020, it was a setback for the resident and he deteriorated after. The Physician stated all of Resident #1's wounds were being treated and there was slight improvement in some of the wounds but couldn't remember in detail about all the wounds. On 01/27/2021 at 2:32 PM, an interview was conducted by the Director of Nursing (DON). the DON stated she had just started at the facility when Resident #1 returned to the facility after a hospital stay on 10/20/2020. The DON stated she had not seen the resident's wound prior to that time, so she did not have anything to compare to. The DON stated the WN should have conducted wound measurements weekly.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		2/22/21

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F 692	Continued From page 17 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain and monitor the body weight of a resident, who was identified as being at risk for nutritional deficit and weight loss, for 1 of 3 sampled residents (Resident #1) reviewed for nutrition status. The findings included: Resident # 1 was admitted to the facility on 07/02/2020 with diagnoses to include history of motor vehicle accident, traumatic brain injury, subarachnoid hemorrhage, pressure ulcer of sacrum, osteomyelitis, and dysphagia. Resident #1's admission weight was recorded in the medical record as 128 pounds. Resident #1's admission Minimum Data Set (MDS) assessment, dated 07/08/2020 revealed resident #1 had severe cognitive impairment. He required extensive 2-person assistance with bed mobility and dressing, and extensive one-person assistance with eating, toilet use, and personal hygiene. The resident was admitted with one stage 4 pressure ulcer. A review of Resident #1's care plan dated 07/14/2020 included a focus of a risk for nutritional deficit related to dysphagia. Interventions included to monitor/document and report any signs and symptoms of dysphagia, and monitor/record/report to the physician signs of malnutrition, significant weight loss.	F 692	Resident #1 was discharged from the facility on 1/13/21. Current residents identified as being at risk for nutritional deficit and weight loss are at risk for the same deficient practice. Current residents were weighed on 2/9/21 by the Certified Nursing Assistant. Weights were reviewed by the Director of Nursing to determine if a re-weigh, weekly or monthly weights were to be implemented. Systemic Measures: Current clinical staff were educated on the weight management process by the Director of Nursing/designee which was completed on 2/21/21. Residents were assessed by the Director of Nursing/designee for nutritional/weight loss risk on 2/10/21. Residents at risk and with noted weight loss were reviewed by the Registered Dietician (RD). for recommendations. This was completed on 2/16/21. The RD recommendations will be provided to the physician for approval during his visit. Orders for nutritional recommendations will be audited for completion during the morning clinical meeting Monday thru Friday by the Director of Nursing/designee X4 weeks and monthly X2 months. Monitoring: Results of the audits will be reviewed	

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F 692	Continued From page 18 On 09/24/2020 the resident's weight was recorded as 126 pounds. The resident was discharged to the hospital on 10/04/2020 and re-admitted on 10/20/2020. Review of the resident's medical record revealed no weight was documented from 10/20/20, when the resident was readmitted to the facility to 11/03/2020. On 01/26/2021 at 3:46 PM, an interview was conducted with Nurse Assistant (NA) #1. The NA stated Resident #1 was able to eat when he was first admitted to the facility, but always needed to be fed. The NA stated Resident #1 had lost weight after returning from the hospital and had a feeding tube. A review of a progress note by the Registered Dietician (RD) dated 10/26/2020 revealed Resident #1 was re-admitted to the facility with a percutaneous endoscopic gastrostomy (PEG) feeding tube. The RD assessed Resident #1's Nutrition requirements based on a body weight of 126 pounds. On 01/29/2020 at 2:23 PM, an interview was conducted with the Registered Dietician (RD) #2. The RD stated she had not seen any residents in person since March 2020. The RD stated she was able to obtain residents' weights with access to the facility's electronic medical records. The RD stated she thought she had sent an email to the DON in 10/2020 to get an updated weight but was unable to find the email or if one was sent. The RD stated when Resident #1 came back from the hospital on 10/20/2020 with a new feeding tube, she assessed the resident on	F 692	during the monthly Quality Assurance Performance Improvement meeting X3 months. Additional interventions will be developed and implemented as deemed necessary by the committee to sustain substantial compliance.	

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10/26/2020 and recommended to increase the amount of feeding the resident was receiving. The RD stated she did not interview staff to see how Resident #1 was doing at that time or request staff to obtain a current weight when she completed Resident #1's nutritional assessment on 10/26/2020. The RD stated according to her calculations on 10/26/2020 she assessed the resident nutritional needs based on the resident's previous weight of 126 pounds that was obtained on 09/24/2020, because that was the most recent weight available when she completed the assessment.

Resident #1's care plan, updated on 11/01/2020 included a focus of a risk for nutritional decline and or weight loss due to receiving 100% of nutrition via gastrostomy (feeding) tube. Interventions included to monitor/evaluate weight and weight changes per facility protocol. The resident's care plan did not address the resident actual weight loss.

Resident #1's weights were recorded as follows:
On 11/4/2020 the resident's weight was recorded as 100.2 pounds.
On 12/30/2020 the resident's weight was recorded as 100.0 pounds.
On 01/07/2021 the resident's weight was recorded as 101.0 pounds.

01/27/2021 at 12:39 PM an interview was conducted with the physician. The physician stated Resident #1 ate well sometimes, was on supplements and was being fed. The physician stated Resident #1 needed more protein because of his wounds but one couldn't over give protein because that could cause kidney problems. The physician stated when the resident contracted the

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F 692	Continued From page 20 COVID-19 virus it was a setback for the resident. The physician stated he had not had a conversation with family or staff prior to the hospitalization in 10/2020 about the need for a feeding tube. The physician stated he was not sure of the resident's weight loss or when it occurred. On 01/29/2021 at 12:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the resident should have had weights on admission, daily for three days and then weekly for a month. If there had been no change, the weights would have continued monthly. The DON stated when Resident #1 returned from the hospital on 10/20/2020 the weight protocol should have started over, but there was no weight taken when the resident returned to the facility until 15 days later on 11/04/2020. The DON stated she missed making sure Resident #1's weight was taken on readmission. The DON stated the facility had problems with getting residents weights taken and they were working to address it.	F 692		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		2/22/21

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and control program (IPCP) that must include, at a minimum, the following elements:

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

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

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F 880	Continued From page 22 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to disinfect a treatment cart and equipment after a dressing change for 1 of 1 wound treatment observation conducted. The findings included: On 01/26/2021 at 10:32 AM, an observation was conducted of wound treatment for Resident #4 by the Assistant Director of Nursing (ADON). Upon arrival to the resident's room, the treatment cart, which was used for storage of multiple supplies for the use of multiple residents, was observed to be in the resident's room, positioned facing the resident's lower half of the bed. Resident #4 turned himself to his right side and exposed his left hip wound, with no dressing. Resident #4 stated he had removed the dressing a couple of hours prior to the dressing change. The ADON donned gloves and cleaned the wound with gauze and wound cleanser. The ADON used the top of the treatment cart as her work area with no barrier placed between the cart and the supplies	F 880	The Assistant Director of Nursing was educated on infection control processes with focus on disinfect treatment equipment and not taking medication or treatment carts into a resident□s room on 1/26/21 by the Administrator/Director of Nursing/designee. Systemic Measures: Staff education on infection control processes with focus on sanitizing equipment and watching the U-Tube CMS training video Sparkling Surfaces was conducted by the Administrator, Director of Nursing, Regional Nurse Consultant/designee which started on 1/26/21 and completed 2/21/21. Three observation audits regarding infection control process will be conducted by the Administrator, Director of Nursing, Regional Nurse Consultant/designee weekly X4 weeks and monthly times 2 months. Negative findings will be	

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F 880	Continued From page 23 used for the resident. The ADON then removed her gloves and opened the bottom drawer to the treatment cart, which came in contact with the blanket and sheet on the resident's bed. The ADON closed the bottom drawer and opened the drawer above it which also touched the bed blanket and sheet. The ADON sanitized her hands, donned gloves and applied medications to the wound and covered with a padded dressing. Scissors, dressing supplies and the wound cleanser were placed on the top of the treatment cart during and after use by the ADON. When finished the ADON pushed the treatment cart out of the resident's room, down the hall and into the medication room, and parked the cart against the wall. The ADON put the scissors and unopened dressing packages from the top of the cart into the top drawer. The ADON was not observed to disinfect any items or the cart prior to storage of the cart. Immediately following this observation, the ADON was interviewed about the lack of disinfection and responded she did not do dressing changes. After the interview, the ADON was observed to retrieve scissors and the unopened dressing packages which she had placed in the cart. The ADON was observed to wipe these items with disinfectant wipes and immediately place them back into the cart. It was observed that the disinfection time printed on the disinfectant wipe container was noted to be four minutes. On 01/26/2021 at 11:05 AM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected staff to follow aseptic technique when conducting wound care. The DON stated the treatment cart should not be taken in to a resident room, and a barrier field should be set up in the resident room. The DON	F 880	corrected when/if noted. Monitoring. Results of the audits will be reviewed during the monthly Quality Assurance Performance Improvement meeting X3 months. Additional interventions will be developed and implemented as deemed necessary by the committee to sustain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	C 01/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 24 stated the wet time for disinfectant use was the time listed on the container. The DON stated she would not expect dressings to be put back in the treatment cart when they had been out in the resident's room, they would be considered dirty. The DON stated she would have the treatment cart disinfected.	F 880		