STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 2/23/2021-2/24/2021. 1 of the 7 complaint allegations was substantiated resulting in a deficiency. See 2567 for further details. Event # F5S011.	F 000		
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 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	F 656		3/19/21

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

Electronically Signed | 03/18/2021

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F 656	Continued From page 1 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: Based on staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 1 of 1 resident (Resident #1) reviewed for discharge to the community. Findings included: Resident #1 was admitted to the facility on 1/5/21 with diagnoses that included, in part, diabetes, osteoarthritis and hypertension. Resident #1 discharged home on 2/4/21. The admission Minimum Data Set (MDS) assessment dated 1/10/21 revealed Resident #1 was cognitively intact. The resident expected to be discharged back to the community and according to the MDS, active discharge planning was occurring for the resident to return to the community. The comprehensive care plan, updated 2/2/21 did not include information that addressed discharge planning. On 2/23/19 at 2:29 PM an interview was	F 656	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? ¿ Resident #1 is no longer in the facility. Discharged on 2/4/21 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ¿ On 3/17/2021 the Social Worker (SW) audited the comprehensive care plans for all current residents (39) for the presence of individualized discharge care planning. The audit revealed that 39 of 39 current residents, had a discharge care plan completed during the most recent comprehensive assessment. ¿ The SW and MDS (Minimum Data Set) Coordinator were reeducated by the Administrator on 2/23/2021 the discharge care planning process. The education included addressing the discharge care	

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F 656	Continued From page 2 completed with the facility Social Worker (SW). She stated for every resident she typically completed a care plan that addressed discharge planning and added if there wasn't a care plan that addressed discharge planning for Resident #1 then she probably had not completed it. The SW thought it had been overlooked due to the busyness of her workload. The MDS nurse was interviewed on 2/23/21 at 3:31 PM. She explained each discipline (including social work) wrote their own care plans. She typically did not write a care plan for discharge planning but thought the SW wrote it. The MDS nurse was aware of the requirement to include discharge plans in the comprehensive care plan and stated the SW was responsible for the specific care plan that addressed discharge planning/goals. MDS nurse said she tried to check that all the care plans included everything but sometimes was unable to go back and check when "things got busy." During an interview with the Administrator on 2/23/21 at 3:57 PM she acknowledged that discharge goals and plans were to be addressed in the care plan and expected staff to include discharge planning in a resident's comprehensive care plan.	F 656	planning needs on the comprehensive care plan. ¿ The SW will discuss discharge care planning needs with the resident/family during the 72-hour post-admission care plan meeting and will develop/document an appropriate discharge plan at that time. ¿ The SW is responsible for ensuring each resident has a discharge care plan addressed via the comprehensive care plan What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? ¿ The SW will initiate a discharge care plan for each new admission. ¿ During any time of the resident□s stay the discharge planning needs change, the SW will discuss the needs during the morning meeting with the IDT and update the discharge care plan accordingly at that time. ¿ The MDS Coordinator is responsible to ensure each resident has a discharge care plan with his/her comprehensive care plan. How will the corrective action be monitored to assure that the deficient practice will not reoccur ¿ The MDS Coordinator will monitor each newly admitted resident and each comprehensive care plan via the audit tool for the presence of discharge care planning needs weekly for four weeks and	

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F 656	Continued From page 3	F 656	monthly for three months. ¿ The MDS Coordinator will track and trend the results via the audit tool and report the findings to the QA (Quality Assurance) committee to determine the need for continued monitoring or alteration to the established plan to ensure compliance. ¿ The MDS Coordinator is responsible for the Plan of Correction	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility Nurse Practitioner interview, the facility failed to assess and treat a laceration and a diabetic foot ulcer on a newly admitted resident upon admission for 1 (Resident #1) of 3 residents reviewed for skin conditions. Findings included: Resident #1 was admitted to the facility on 1/5/21 from the hospital following a fall at home with diagnoses that included: Left knee laceration due to traumatic fall, Left knee immobilizer, Bilateral transmetatarsal amputations, Diabetes mellitus with neuropathy to lower extremities, Right foot diabetic ulcer on plantar surface, Right lower extremity soft cast with cast sandal.	F 658	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? ¿ Resident #1 no longer resides in the facility. Discharged 2/4/21 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ¿ The Director of Nursing will complete 100% skin assessments by 3/19/2021 on all residents to ensure residents with wounds have wound treatment orders with	3/19/21

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F 658	Continued From page 4 Resident #1's admission Minimum Data Set dated for 1/10/21 revealed that she was cognitively intact and had a surgical wound. The hospital discharge summary dated 1/5/21 included documentation of a recent fall at home that required 18 stiches to Resident #1's left knee. Discharge orders included Keflex 500 milligrams (mg) twice daily for 5 days and an appointment to follow up with an orthopedist in 2 weeks. No wound care orders were included in the discharge summary. Record review revealed the following nurse note on 1/5/21 at 11:00 PM including, in part: " ...Diabetic has had all of toes amputated. Has diabetic ulcer on right toe that she's supposed to call wound clinic on discharge for care. Has boot on right foot ...immobilizer on left leg stated has 18+ stitches where she fell at home ... Plan for toe: antibacterial soap Barrier cream around outside of wound and accucell and gauze every 3 days." Further record review revealed that no initial skin assessment was found in Resident #1's chart. Record review of Resident #1's chart revealed that the facility first addressed her left knee wound and her right foot wound on 1/19/21 when she was seen by the facility Nurse Practitioner (NP) who also was the facility wound nurse. An interview with Nurse #2 on 2/23/21 at 3:24 PM revealed that she admitted Resident #1 to the facility on 1/5/21. She stated all skin assessments were done as part of the admission process and were uploaded in resident charts but	F 658	proper documentation. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? ¿ The Director of Nursing will reeducate on 2/24/2021 for all licensed nurses on wound treatments, orders, and proper documentation. ¿ All new hire nurses will be educated during orientation. ¿ The Director of Nursing/Assistant Director of Nursing/Unit Manager will assess all new admission/readmissions with skin assessments to ensure proper treatment orders are in place and documentation of any skin conditions is correct ¿ The Director of Nursing will reeducate on 2/24/2021 for all licensed nurses on correct order entry. ¿ All new hire nurses will be educated during orientation. How will the corrective action be monitored to assure that the deficient practice will not reoccur ¿ The Director of Nursing/Assisted Director of Nursing/Unit Manger will review all new orders 5 times a week for 3 months to ensure wound care or skin treatment orders are correctly entered.	

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F 658	Continued From page 5 admitted she didn't remember if she did one for Resident #1. When asked about the plan for the toe, she stated she believed she heard that from a nurse at the hospital who called report prior to Resident #1 arriving at the facility. An interview with Nurse #1 on 2/23/21 at 2:47 PM revealed that she had been at home on quarantine for two weeks and had returned to work on 1/19/21. Nurse #1 stated that Resident #1 was under her care the day that she returned. She stated she asked Resident #1 about the bandages on her left knee and right foot and that Resident #1 stated that they had not been looked at by anyone since she was admitted to the facility. Nurse #1 stated the wound pad on Resident #1's left knee contained a small amount of dried blood with no drainage noted from the sutures. She then stated she brought it to the attention of the NP and asked her to evaluate. An interview with the NP on 2/23/21 at 2:30 PM revealed that she was unaware of any wounds on Resident #1 and was asked by Nurse #1 on 1/19/21 to evaluate and provide treatment recommendations for Resident #1's left knee and right foot wounds. The NP stated that the right foot wound had a small amount of serosanguinous discharge with no signs of infection. She also stated that her left knee wound appeared to be slightly pink with no drainage. The NP added that Resident #1 was seen by her orthopedist later that same day for a previously scheduled appointment. A record review of an orthopedist appointment dated for 1/19/21 revealed, in part, the following note: "Two week open left knee wound with knee immobilizer follow up. Wound has no drainage;	F 658	¿ The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. ¿ The Director of Nursing is responsible for the Plan of Correction	

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F 658	Continued From page 6 slightly red with scab covered. Follow up in 1 week for possible suture removal. Continue immobilizer and weight bearing as tolerated." An interview with the Administrator and Director of Nursing on 2/23/21 at 12:35 PM revealed that they had been made aware of the incident and were in the process of taking the necessary steps to prevent it from happening in the future. Both stated it was their expectation that skin assessments were to be performed on every admission to the facility.	F 658		