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 _____	R-C 03/10/2022

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

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted 03/07/22 with exit from the facility on 03/07/22. Additional information was obtained offsite through 03/10/22; therefore, the exit date was changed to 03/10/22. Repeat tags were cited. The facility remains out of compliance. The Directed Plan of Correction including the Root Cause Analysis were reviewed. Event ID #R3LG14	{F 000}		
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 record review and staff interviews, the facility failed to implement their abuse policy and procedure by not reporting an allegation of staff-to-resident abuse to the State Agency within 2 hours of being notified and failed to notify the Administrator and Adult Protective Services (APS) when an allegation of staff-to-resident abuse was reported to staff for 1 of 3 sampled residents reviewed for abuse (Resident #1). Findings included:	F 607	1. The facility failed to implement their abuse policy and procedure by not reporting an allegation of staff-to-resident abuse to the North Carolina (NC) State Agency within 2 hours of being notified and failed to notify the Administrator and Adult Protective Services (APS) when an allegation of staff-to-resident abuse was reported to staff for 1 of 3 sampled residents reviewed for abuse (Resident #1). The Administrator was notified on 12/20/2021 of the allegation of	3/12/22

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

Electronically Signed | 03/11/2022

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F 607	Continued From page 1 The facility policy titled, "Abuse, Neglect and Exploitation implemented 11/01/20, read in part: "it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. All alleged violations will be reported to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: Immediate, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." Resident #1 was admitted to the facility on 12/16/21 with multiple diagnoses that included dementia and major depressive disorder. A nurse progress note written by Nurse #2 and dated 12/19/21 at 3:31 PM read in part, Resident #1's family member called stating that a Certified Nurse Aide (CNA) put a bruise on Resident #1's wrist the previous night. Resident #1's family member further stated, another family member had visited Resident #1 the previous evening and sent a picture of her wrist but did not inform any staff. The Director of Nursing (DON) was contacted and informed of the situation. An interview with Nurse #2 on 03/08/22 at 10:41 AM revealed sometime between 8:00 PM to 10:00 PM on 12/18/21, a family member of Resident #1 called and stated a nurse had put a bruise on Resident #1 the previous night. Nurse	F 607	staff-to-resident abuse that occurred on 12/18/2021. An investigation was started immediately upon notification to the Administrator and allegation was reported to NC State agency on 12/20/22 by 24-hour report and to APS on 3/11/2022. 2. All current facility residents are at risk of being affected by the deficient practice of the facility failing to implement their abuse policy and procedure by not reporting an allegation of abuse to the State Agency within 2 hours of being notified and failing to notify the Administrator and APS when an allegation of abuse is reported to staff. Current facility residents with a Brief Interview for Mental Status (BIMS) of twelve (12) or greater will be interviewed by Social Services Director or Designee to assess their feeling of safety in their environment and with their caregivers. Current facility residents with a BIMS less than twelve (12) will have a body audit completed by a licensed nurse to assess for any signs of injuries that could indicate abuse. Interviews and body audits to be completed on 3/11/2022. Any findings indicative of possible abuse will be reported to the Administrator immediately and reported to State Agency and APS within 2 hours of notification per the facilities abuse policy and procedure. No allegations of abuse reported. 3. The measures that have been put in place to ensure the deficient practice does not recur are as follows; the Administrator and Director of Nursing began education	

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F 607	Continued From page 2 #2 stated the family member did not indicate what time the bruising had allegedly occurred. Nurse #2 stated she notified the DON after she spoke with Resident #1's family member on the phone and before she went in to talk to Resident #1 about the bruising. The DON told Nurse #2 that she would "handle it" and she did not hear back from the DON the rest of the night. Nurse #2 stated the DON was supposed to call the Administrator to inform him of the allegation. Review of the facility's investigation revealed the facility was made aware of the alleged abuse reported by Resident #1 on 12/20/21 at 11:15 AM and the initial report was submitted to the State Agency via fax transmission on 12/20/21 at 1:05 PM. Further review revealed Adult Protective Services was not notified. An interview with the previous Interim DON on 03/08/22 at 10:26 AM revealed she did not really remember the incident involving Resident #1 and wasn't really involved in the abuse investigation. The DON stated she did not remember being called about the allegation of abuse made by Resident #1 on 12/18/21. An interview with the Administrator on 03/07/22 at 5:17 PM revealed his expectation was for all allegations of abuse to be reported to him immediately and/or as soon as the staff became aware of the allegation. The Administrator confirmed he was not informed of the allegation of abuse made by Resident #1 on 12/18/21 until the morning of 12/20/21 and an investigation was immediately initiated.	F 607	with current facility and agency staff on Abuse, Neglect, and Exploitation Policy and Procedure on 3/11/2022. Education includes, 1) Types of abuse 2) Signs of Abuse 3) What to do if you witness abuse 4) How to report abuse 5) Complete overview of Abuse, Neglect, and Exploitation Policy. Education to current facility and agency staff will be completed effective 3/12/2022. Newly hired facility and agency staff and those who did not receive education by 3/12/2022 receive education during orientation and prior to working. Effective 3/12/2022 all facility staff will immediately report any allegation of resident abuse to the Administrator. The Administrator is available 24/7 by cell phone. The Administrator's cell phone number is posted at each nurses station. The Administrator will report to State Agency and APS within 2 hours of notification of abuse allegation and initiate investigation per the Abuse, Neglect and Exploitation Policy and Procedure. 4. The Administrator or designee will interview five (5) residents with a BIMS of greater than twelve (12) weekly for four (4) weeks, then five (5) residents every other week for four (4) weeks, and five (5) residents monthly for one (1) month to ensure they feel safe with their caregivers and in their environment. The Director of Nursing or designated licensed nurse will conduct five (5) body audits on residents with BIMS of twelve (12) or less weekly for four (4) weeks, five (5) residents every other week for four (4) weeks, and five (5) residents monthly for one (1) month. The	

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F 607	Continued From page 3	F 607	Director of Nursing or Administrator will monitor twenty-four (24) hour report progress notes three (3) times a week for 12 weeks to ensure allegations of abuse, neglect, and exploitation are reported per policy and procedure. Data from audits will be brought to Quality Assurance Performance Improvement Committee by Administrator monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary. 5. Completion Date: 3/12/2022	
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a complaint survey conducted on 9/20/21. This was for two deficiencies originally cited on 9/20/21. The deficiency in the area of Infection Control was cited again during three revisit surveys on 11/12/21, 12/17/21 and 03/10/22. The deficiency in the area of Develop/Implement Abuse/Neglect Policies was cited again during the revisit survey on 03/10/22.	{F 867}	1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a complaint survey conducted on 9/20/21. This was for two deficiencies originally cited on 9/20/21. The deficiency in the area of Infection Control (F880) was cited again during three revisit surveys on 11/12/21, 12/17/21 and 03/10/22. The deficiency in the area of Develop/Implement Abuse/Neglect	3/12/22

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{F 867}	Continued From page 4 This continued failure of the facility during the past complaint and revisit surveys show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F 607: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not reporting an allegation of staff-to-resident abuse to the State Agency within 2 hours of being notified and failed to notify the Administrator and Adult Protective Services (APS) when an allegation of staff-to-resident abuse was reported to staff for 1 of 3 sampled residents reviewed for abuse (Resident #1). During the complaint survey of 9/2021 the facility was cited for failing to implement their abuse policy and procedure by not submitting an initial or 5-day investigative report for 1) an injury of unknown origin for a dependent resident with swelling noted to her leg that was subsequently determined to be a fracture and 2) an allegation of resident-to-resident abuse within 2 hours of being notified to the Division of Health Service Regulation (DHSR) for 2 of 4 sampled residents reviewed for abuse. F 880: Infection Prevention and Control: Based on record review, observations, and interviews with staff the facility failed to ensure infection prevention procedures for hand hygiene were followed when Nurse #1 and Nurse #2 failed to perform hand hygiene after gloves were removed during a dressing change for 3 of 3 residents reviewed for wound care (Resident #1, Resident	{F 867}	Policies (F607) was cited again during the revisit survey on 03/10/22. This continued failure of the facility during the past complaint and revisit surveys show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. 2. All current facility residents are at risk of being affected by the deficient practice. 3. On 3/11/2022 an AD Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held with the Administrator, Director of Nursing, Minimum Data Set Nurse, and Medical Director in attendance. A root cause analysis was completed, reviewed, and discussed for F607 and F880. The root cause for the recurring deficient practice of F607 was facility and agency staff need reeducation on Abuse, Neglect and Exploitation policy and clarification on definition of an allegation. The root cause for F880 was Staff have a lack of knowledge surrounding rationale of hand hygiene practices regarding infection control and a need for ongoing oversight and training using multiple modalities. 4. The measures that have been put in place to ensure the deficient practice does not recur are as follows; the Administrator and Director of Nursing (DON) were educated on development of an effective Quality Assurance and Performance Improvement (QAPI) committee consisting Administrator, DON, Dietary	

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{F 867}	Continued From page 5 #2, and Resident #3). During the complaint survey of 9/20/21 the facility was cited for failure to ensure staff handled soiled linen and a soiled brief in a sanitary manner for 1 of 1 resident reviewed for infection control. During the revisit survey on 11/12/21 the facility was cited for failure to ensure staff changed gloves and performed hand hygiene when going from a dirty to a clean task and failed to remove soiled gloves and perform hand hygiene after completing wound care for 1 of 1 resident reviewed for wound care. During the revisit and complaint investigation survey on 12/17/21, the facility was cited for failure to ensure infection prevention procedures for hand hygiene were followed when Nurse #1 and Nurse #2 failed to perform hand hygiene after a dressing change for 3 of 3 residents reviewed for wound care. During an interview on 03/09/22 at 10:04 AM, the Administrator revealed after the previous revisit and complaint investigation surveys, facility staff were re-educated on the facility's procedures for reporting alleged abuse and hand hygiene. Regarding the recent survey of 03/10/22, the Administrator explained Nurse Aide #1 was normally very conscientious about following infection control procedures and felt her not performing hand hygiene during incontinence care was due to being nervous as well as her mother had just passed away. The Administrator recalled when he discussed the abuse allegation with the previous Interim Director of Nursing, she had confirmed the staff had notified her of the situation involving Resident #1 on 12/18/21 but	{F 867}	Manager, Social Services Director, Director of Rehab, Activities Director, Medical Director, Business Office, Maintenance Director, and Housekeeping Director that consists of processes that 1) Identify and use data to monitor our performance 2) Establish goals and thresholds for our performance measurement 3) Utilize resident, staff and family input 4) Identify and prioritize problems and opportunities for improvement 5) Systematically analyze underlying causes of systemic problems and adverse events 6) Develop corrective action or performance improvement activities. Education was completed on 3/11/2022 by the Regional Director of Clinical Services. The Administrator will educate the members of the QAPI committee of expectations of the committee to 1) Identify and use data to monitor our performance 2) Establish goals and thresholds for our performance measurement 3) Utilize resident, staff, and family input 4) Identify and prioritize problems and opportunities for improvement 5) Systematically analyze underlying causes of systemic problems and adverse events 6) Develop corrective action or performance improvement activities. Education of committee will be completed by 3/12/2022. Newly hired Administrators, Director of Nurses, or QAPI committee members will be educated upon hire. Effective 3/12/22, the QAPI committee will meet monthly to review the results of the facilities ongoing monitoring of the Infection Control Program (F880) and the Abuse, Neglect	

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{F 867}	Continued From page 6 during the conversation, staff did not give her any inclination that an allegation of abuse was made which was why she did not notify him on 12/18/21. He added when he started his investigation on 12/20/21, he determined staff were aware of the allegation of abuse on 12/18/21 and he should have been notified.	{F 867}	and Exploitation Policies and Procedures (F607) and evaluate effectiveness and make changes to the plan as necessary to maintain compliance. The Regional Director of Clinical Services and Regional Director of Operations attend monthly for 3 months and as needed to provide oversight and to ensure the facility is sustaining an effective QAPI program to prevent repeat deficient practices. 5. The Regional Director of Clinical Services and Regional Director of Operations will attend Quality Assurance Performance Improvement Meetings Monthly for 3 months for oversight to ensure the facility is sustaining an effective QAPI Program. QAPI minutes will be submitted to Regional Director of Operations and Regional Director of Clinical Services monthly for 6 months. At that time it will be decided if further oversight is needed of the facilities QAPI process. 6. Completion Date: 3/12/2022	
{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	{F 880}		3/12/22

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{F 880}	Continued From page 7	{F 880}		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(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

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{F 880}	Continued From page 8 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement infection prevention procedures for hand hygiene by not removing gloves and/or sanitizing hands after providing incontinence care for 1 of 3 residents (Resident #2) by 1 of 2 facility staff (Nurse Aide #1) observed for infection control practices. Findings included: Review of the facility's policy titled "Hand Hygiene" last revised 10/29/20 read in part: "Hand hygiene" is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.	{F 880}	F880 (DPOC Tier 1) 1. The facility failed to implement infection prevention procedures for hand hygiene by not removing gloves and/or sanitizing hands after providing incontinence care for 1 of 3 residents (Resident #2) by 1 of 2 facility staff (Nurse Aide #1) observed for infection control practices. On 3/7/2022, Nurse Aide #1 was educated immediately upon the Director of Nursing being made aware of the breach in infection control practice. Resident #2 will continue receiving incontinence care with appropriate infection control measures being followed. 2. All current facility residents who require incontinence care are at risk of being affected by the deficient practice. Director of Nursing started educating nurse aides on correct hand hygiene and	

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{F 880}	Continued From page 9 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 3. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The attached Hand Hygiene Table listed in part the following as indications for using either soap and water or ABHR: a. After handling contaminated objects b. Before applying and after removing personal protective equipment (PPE), including gloves c. After assistance with personal body functions (e.g. elimination) A continuous observation of NA #1 on 03/07/22 from 01:55 PM to 2:04 PM revealed NA #1 provided incontinence care for Resident #2. With gloved hands, NA #1 cleaned stool with resident care wipes, removed the soiled brief and placed it at the foot of the bed, placed a clean brief under Resident #2, and secured the tabs of the brief. NA #1 adjusted Resident #2's gown, pulled up Resident #2's bed cover, adjusted her pillow, and moved the overbed table closer to Resident #2, all while still wearing the gloves used to provide incontinence care. NA #1 picked up the soiled brief from the end of the bed, walked to the bathroom, opened the bathroom door and placed the soiled brief in a trash bag, closed the bathroom door, and walked out in the hall. NA #1 placed the trash bag containing the soiled brief in	{F 880}	soiled brief handling procedure on 3/7/2022. 3. The measures that have been put in place to ensure the deficient practice does not recur are as follows; The Director of Nursing or Designee will educate current facility and agency licensed nurses and nurse aides on hand hygiene during incontinence care and proper placement of soiled briefs during and after incontinence care with verbal confirmation of understanding. Initial education will be completed by 3/12/2022, in addition to the nursing staff education, all current facility and agency staff will be educated on hand hygiene by Director of Nursing and will be completed by 3/12/2022. Further education will be conducted including hands on training with return demonstrations to be completed by current facility and agency staff to help ensure compliance and understanding. Newly hired facility and agency staff and those who did not receive education by 3/12/2022 will receive education during orientation and prior to working. 4. The Director of Nursing or designee will monitor by visual observation infection control practices including hand hygiene and soiled brief disposal during incontinence care ten (10) times weekly for four (4) weeks, five (5) times a week for eight (8) weeks, and ten (10) times a month for three (3) months to ensure proper practices are followed. During audits any infractions will be corrected at	

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{F 880}	Continued From page 10 her right hand, removed her left glove and placed it in her right hand, pulled her right glove down partially over her hand, walked down the hall to the soiled utility room, and opened the soiled utility room door with her left hand. NA #1 discarded the soiled brief in the soiled utility room. NA #1 did not remove her gloves and perform hand hygiene after removing stool during incontinence care and continued to touch other items and surfaces while wearing soiled gloves. During an interview with NA #1 on 03/07/22 at 2:05 PM she confirmed she wore the same gloves after removing stool during incontinence care that she used to touch other items in Resident #2's room. She stated she usually removed her soiled gloves after providing incontinence care, performed hand hygiene, donned a clean pair of gloves if needed, and then completed resident care. NA #1 was unable to state why she did not remove her soiled gloves and perform hand hygiene before completing resident care, but stated she did just bury her mother on 03/06/22. She stated she should have had a trash bag available to place the soiled brief in rather than sitting it on the foot of the bed. An interview with the Director of Nursing (DON) on 03/07/22 at 04:06 PM revealed she expected staff to remove soiled gloves and perform hand hygiene after providing incontinence care and before touching other items in the resident's room. An interview with the Minimum Data Set (MDS) Coordinator on 03/07/22 at 04:09 PM revealed he had been assisting the DON with Infection Prevention since she became the DON a little over a week ago. He stated he expected staff to	{F 880}	that time. The Director of Nursing will collect data from audits, and it will be brought to the Quality Assurance Performance Improvement (QAPI) committee meeting monthly for 6 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary. 5. Completion Date: 3/12/2022	

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 _____	R-C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 880}	Continued From page 11	{F 880}		

remove soiled gloves and perform hand hygiene after providing incontinence care and before touching other items in the resident's room.

An interview with the Administrator on 03/07/22 at 05:53 PM revealed he expected nursing staff to follow the hand hygiene policy when providing incontinence care.

A follow-up interview with the DON on 03/08/22 at 03:20 PM revealed she expected staff to place soiled briefs in a trash bag. She stated when care was complete the soiled gloves should be placed in the trash bag, and the bag should be discarded in the appropriate location.