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 03/15/2022

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 000}	INITIAL COMMENTS An onsite fourth revisit was conducted 03/13/22 to 03/14/22 with exit from the facility on 03/14/22. Additional information was obtained offsite on 03/15/22; therefore, the exit date was changed to 03/15/22. Repeat tags were cited. The resident census is 57. The facility remains out of compliance. Event ID #R3LG15. The first survey in the enforcement cycle for Accordius Health at Brevard was completed on September 20, 2021. In accordance with 42 C.F.R. § 488.412, CMS cannot allow the facility to participate in the Medicare program for more than six months after that date, unless the facility returns to substantial compliance with the Federal Participation requirements for the Medicare program before that point. Four revisit surveys have been conducted that reveal the nursing facility has failed to achieve substantial compliance.	{F 000}		
{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 facility interviews with staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain to montior for compliance with policies and procedures and monitor the interventions that the committee put into place	{F 867}	F867 1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain to monitor for compliance with policies and procedures and monitor the	3/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/16/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 867}

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following a complaint survey conducted on 9/20/21. This was for one deficiency in the area of Infection Control that was originally cited on 9/20/21 and subsequently recited during four revisit surveys on 11/12/21, 12/17/21, 03/10/22, and 03/15/22. This continued failure of the facility during the past four revisits and complaint investigation 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 880: Based on observations, record review, and staff interviews the facility failed to implement hand hygiene when Nurse Aide #1 did not wash her hands after she removed her gloves when providing incontinence care and before touching other items in the room for 1 of 3 nursing staff observed to provide incontinence or wound care for 1 of 3 sampled residents reviewed for infection control (Resident #1).

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 second 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 third revisit and complaint investigation survey on 12/27/21, the facility was cited for

{F 867}

interventions that the committee put into place following a complaint survey conducted on 9/20/21. This was for one deficiency in the area of Infection Control that was originally cited on 9/20/21 and subsequently recited during four revisit surveys on 11/12/21, 12/17/21, 03/10/22, and 03/15/22. This continued failure of the facility during the past four revisits and complaint investigation 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 3/15/2022 an AD Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held with the Administrator, Director of Nursing, Regional Director of Clinical Services, and Medical Director in attendance. A root cause analysis was completed, reviewed, and discussed for F880. The root cause for F880 was determined to be an isolated error by NA #1. Staff member had been educated on proper hand hygiene during incontinence care but became nervous due to being watched by surveyor and forgot to perform proper steps.

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 re-educated on development of an effective Quality Assurance and

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{F 867}	Continued From page 2 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 the fourth revisit and complaint investigation survey on 03/10/22, 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 gloves were removed during a dressing change for 3 of 3 residents reviewed for wound care (Resident #1, Resident #2, and Resident #3). During an interview on 3/13/22 at 6:28 PM and follow-up interview on 03/15/22 at 10:06 AM, the Director of Nursing (DON) revealed since she started her position as the DON a few weeks ago, she trained nursing staff on when and how to perform hand hygiene and checked off their skills during return demonstrations. The DON added she continued to perform weekly observations of staff washing their hands at appropriate times including after contact with a resident. During an interview on 03/14/22 at 6:22 PM, the Administrator revealed after the previous revisit and complaint investigation surveys, facility staff were re-educated on hand hygiene, most recently on 03/10/22, and that training included observations of return demonstrations and monitoring by the Director of Nursing. He added when staff were observed and monitored for hand hygiene during incontinence and wound care, concerns weren't really identified and felt nerves played a role with the infection control concerns identified during the current and previous surveys.	{F 867}	Performance Improvement (QAPI) committee consisting of Administrator, DON, Dietary 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 3/16/2022 by the Regional Director of Clinical Services. The Administrator re-educated 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 p/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 was completed on 3/16/2022. Newly hired Administrators, Director of Nurses, or QAPI committee members will be educated upon hire. Effective 3/16/22, the QAPI committee will meet monthly to review the results of the facilities ongoing	

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{F 867}	Continued From page 3 The Administrator stated, "another factor he felt contributed was they did not have a lot of consistency with the agency staff utilized. Most worked as needed, which left the facility with no control over who would be available to work, and the agency staff they may have requested for a particular shift/day might have been sent somewhere else." The Administrator stated "as of the last week in February 2022, they started contracting with agency staff for 13-week increments in an effort to increase continuity of the staff." In addition, the Administrator stated some Nurse Aides that were previously employed by the facility and familiar with the facility's protocols, have now returned to work at the facility as agency staff. The Administrator described the monitoring tools created as part of the 03/12/22 Plan of Correction but indicated they had not yet started the monitoring process. He added the DON would be starting this week (03/14/22) observing 10 random residents, across different shifts, being provided incontinence care by nursing staff and will continue the montioring each week for a period of 4 weeks. The Administrator stated "he felt the facility was headed in the right direction with the addition of the new Director of Nursing who had been an employee of the facility for several years and longer contracts with agency staff."	{F 867}	monitoring of the Infection Control Program (F880) and evaluate effectiveness and make changes to the plan as necessary to maintain compliance. The Regional Director of Clinical Services or Regional Director of Operations will 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 or 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: 3/16/2022	
{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	{F 880}		3/16/22

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{F 880}	Continued From page 4 diseases and infections. §483.80(a) Infection prevention and control 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	{F 880}		

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{F 880}	Continued From page 5 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 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 hand hygiene when Nurse Aide #1 did not wash her hands before having direct contact with a resident, after gloves were removed, after incontinence care for a soiled resident was provided, and before other items were touched in the room for 1 of 3 nursing staff observed to provide incontinence or wound care for 1 of 3 sampled residents reviewed for infection control (Resident #1). The findings included: A review of the facility's policy revised on August 2015 titled; "Handwashing/Hand Hygiene" read in part: "This facility considers hand hygiene the	{F 880}	F880 1. The facility failed to implement hand hygiene when Nurse Aide #1 did not wash her hands before having direct contact with a resident, after gloves were removed, after incontinence care for a soiled resident was provided, and before other items were touched in the room for 1 of 3 nursing staff observed to provide incontinence or wound care for 1 of 3 sampled residents reviewed for infection control (Resident #1). On 3/13/2022, Nurse Aide was re-educated immediately upon the Director of Nursing (DON) being made aware of the breach in infection control practice. DON completed direct observation and competency check off for	

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primary means to prevent the spread of infection."
1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.

2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

7. Use an alcohol-based hand rub or soap and water for the following situations:
b. Before and after direct contact with residents.
h. Before moving from a contaminated body site to a clean body site during resident care.
m. After removing gloves.

Review of an in-service for Hand Hygiene revealed the signature of Nurse Aide (NA) #1 indicating she received training on 3/10/22.

During a continuous observation on 3/13/22 from 1:33 PM to 1:43 PM NA #1 donned a new pair of gloves and assisted Resident #1 from the wheelchair to the bed then removed the resident's pants and unfastened the incontinence brief. NA #1 removed her gloves and donned a new pair and begun to provide Resident #1 with incontinence care by using a premoistened wipe to clean the front peri area then repositioned the resident. NA #1 used a premoistened wipe to clean Resident #1's buttocks until a smear of stool was removed. NA #1 removed and discarded her gloves in the trash then donned a

{F 880}

nurse aide on infection control practices while performing incontinence care. Resident #1 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 re-educating current facility and agency nurse aides on correct hand hygiene on 3/13/2022.

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 nurse aides on hand hygiene during incontinence care and after incontinence care utilizing a mannequin to do hands-on demonstration of skills learned and competency check off. Initial education will be completed on 3/16/2022.Newly hired facility and agency nurse aides and those who did not receive education on 3/16/2022 will receive education during orientation and prior to working. The Medical Director will also be doing an Infection Control In-service for facility and agency nursing staff on 3/23/2022 for further education. Effective 3/16/2022 facility and agency nurse aides will follow proper infection control procedures by changing gloves and practicing hand hygiene when moving from dirty to clean during the incontinence care process.

4. The Director of Nursing or designee

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{F 880}	Continued From page 7 new pair and begun to rub a white cream on Resident #1's buttocks. While wearing the same gloves NA #1 assisted Resident #1 to reposition on her back and used both hands to cover Resident #1 with the blanket from the bed. NA #1 removed and discarded her gloves in the trash then used the bed remote to put the bed in a low position then walked to the bathroom located in Resident #1's room and begun to wash her hands with soap and water. NA #1 checked Resident #1 before leaving the room then used the dispenser of alcohol-based hand rub attached to the wall to sanitize her hands before she left the room. An interview was conducted with NA #1 on 3/13/22 at 1:43 PM. NA #1 confirmed Resident #1 had an incontinent episode and she had removed a small amount of stool during care. NA #1 stated she was trained to remove her gloves and perform hand hygiene after contact was made with body fluids such as stool before moving forward with care. NA #1 stated she realized she missed a step when she did not remove her gloves and perform hand hygiene after Resident #1 was cleaned for an incontinence. During an interview on 3/13/22 at 6:28 PM the Director of Nursing (DON) revealed she observed nursing staff perform incontinence care and trained when to perform hand hygiene. The DON revealed she continued to do the weekly observations of staff washing their hands at appropriate time. The DON stated she would expect NA #1 to wash or sanitize her hands after cleaning stool during incontinence care before moving forward with care or a clean process.	{F 880}	will monitor by visual observation infection control practices including hand hygiene 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 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: 3/16/2022	

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{F 880}	Continued From page 8 An interview was conducted on 3/13/22 at 6:49 PM with the Administrator. The Administrator revealed the DON had observed incontinence care for residents. He revealed those observations were random and spread out across different shifts and stated all nursing staff had been trained and expected hand hygiene was performed after a dirty process such as incontinence care. A follow-up interview was conducted on 3/15/22 at 10:06 AM with the DON. Since started in position the DON stated she trained staff and checked skills during their demonstration of hand hygiene. The DON revealed NA #1 had received education on when to perform hand hygiene and incontinence care.	{F 880}		