STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT LEXINGTON	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 3/7/22 through 3/8/22. Event ID# FF1S11 One of the eleven complaint allegations was substantiated resulting in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		3/28/22

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

Electronically Signed | 03/31/2022

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility failed to treat a resident in a dignified manner when there was a delay in answering a resident ' s call light for one of two residents (Resident #5) reviewed for dignity. The findings included: Resident #5 was admitted to the facility on 2/28/22 with multiple diagnoses which partly included: Dysphagia (difficulty swallowing), history of stroke, diverticulitis, presence of a feeding tube, and adult failure to thrive (FTT). The Minimum Data Set (MDS) admission comprehensive assessment with an Assessment Reference Date (ARD) of 3/3/22 indicated Resident #5 was cognitively intact and had no behaviors during the assessment period. The resident was coded as requiring supervision with the assistance of one to two people for bed mobility and dressing. He was coded as requiring limited to extensive assistance of one to two people for toilet use and personal hygiene. Further review revealed the resident was always continent of bowel and occasionally incontinent of	F 550	Based on record review, observations, resident and staff interviews, the facility failed to treat a resident in a dignified manner when there was a delay in answering a resident's call light for one of two residents reviewed for dignity. On 3/24/2022 Resident #5 was audited for answering of call light in a timely manner by the Administrator. The resident's call light was answered in a timely manner by Certified Nursing Assistant. Resident #5 was interviewed by the Administrator regarding needs being met by the facility. Resident #5 reported during his interview that all his needs were met. On 03/25/22 the Social Worker or designee completed a 100% interview of all alert and oriented residents regarding timeliness of call light response. On 3/25/2022 the Director of Nursing reviewed all non-alert and oriented residents for timeliness of call light response. No negative outcomes were identified. On 3/24/2022 the Director of Nursing initiated re-education with all staff and on answering call lights timely. Facility staff to	

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F 550	Continued From page 2 urine. A continuous observation was conducted on 3/7/22 of the 100 hall which started 10:15 AM. There were three rooms observed with call lights on at 10:15 AM which included rooms 103, 105, and 110. Room 105 was observed to have multiple linens (wash cloths and towels) on the floor at the doorway, and there were brown marks on the door to the hall, where the linens were. Further observation revealed Resident #5 in the A bed in room 105, with no clothing over his genitals. At 10:28 AM the Activities Director (AD) was observed to walk past Resident #5 ' s room once when she went to answer the call light in room 110, and then again when she left room 110, and went back towards the nurses ' station. At 10:31 AM, the AD went to Resident #5 ' s room, got the resident some wash cloths, and the resident was heard telling the AD he had been sitting in his own waste for 3 hours. The AD was then observed leaving the resident ' s room. At 10:34 AM, Resident #5 was observed to throw a soiled wash cloth into the pile of linens at the doorway. At 10:38 AM, the resident asked the surveyor for assistance. At 10:40 AM NA #1 and NA #2 came to the 100 hall. At 10:41 AM the NAs went into room 105 to assist Resident #5. At 10:53 AM NA #1 had assisted Resident #5, he was dressed, and he was in the hall, in a wheelchair. An observation conducted by Surveyor #2 at 10:24 AM on 3/7/22 of the 200 hall revealed Nursing Assistant (NA) #1 and NA #2 assisting residents on that hall with care. Further observation revealed Nurse #1 on the 300 hall at a medication cart, and no staff observed at the 100/200/300 halls nurses ' station. The call light	F 550	include agency staff and new hires will not work until the required education is complete. The Director of Nursing or designee will audit 10 residents weekly x 3 months beginning 3/28/2022. Audits will be documented on Call light monitoring log to ensure resident call lights are answered in a timely manner. The call light log will be brought to monthly Quality Assurance and Performance Improvement Committee x 3 months by the DON or designee for review. Any further action needed will be implemented by the committee as required.	

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annunciator could be heard making a repeated tone and there were lights on, on the annunciator board indicating pending ringing call lights.

During interviews conducted on 3/7/21 with NA #1 at 10:59 AM and 2:44 PM, she stated she was an agency NA and she was the only NA working the 100 hall side of the 100/200/300 hall side of the facility. She explained Resident #5 did not want a shower when she was in the room earlier, he wanted to get out of bed, didn ' t want to be washed up, but she was able to provide incontinence care, and he wanted to go to the activity. She explained she had not worked on that side of the building (100/200/300 halls) frequently, and it had been just her and NA #2 to care for the residents of the three halls. She said it was her first day she had assisted Resident #5 with his care. She said she was not aware he had been incontinent of stool until she had got to his room. She stated when she and the other NA were down on the 200 hall assisting residents with care, it was only the two of them, and they were on that hall, so she was unaware of any call lights which may have been on for the 100 hall.

NA #2 stated during an interview conducted on 3/7/22 at 1:43 PM she did not have the 100 hall, and was working on the 200 hall. She said there was just her and the one other NA for the 100 hall, 200 hall, and 300 hall.

An interview was conducted with Resident #5 on 3/7/22 at 2:24 PM. He stated he had sat in feces for 2 hours and 17 minutes that morning. He demonstrated how he had kept track of the time by turning his television on and the display had the time on it. The resident stated it made him

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feel awful and angry. He admitted he had thrown the linens out into the hallway because he just wanted something to clean himself up with. He further stated he had asked the nursing staff in the morning to unhook him from the feeding tube to go to the bathroom, but he wasn ' t unhooked. He said he had explained to the staff he had a bowel movement at the same time every day, and if he were unhooked from the feeding tube, he could go to the bathroom by himself. He explained despite telling the facility staff his daily routine, they did not unhook him from the feeding tube. The resident also stated the facility had provided him a bedside commode after he had been incontinent in the bed earlier in the day and it had made a mess. The resident explained he did not think it was right he was continent of bowel, but because he couldn ' t get to the bathroom, to have a bowel movement, he had a bowel movement in the bed.

Nurse #1 was interviewed on 3/7/22 at 2:58 PM and she stated she had passed medication on the 100 hall and the 300 hall during the morning. She said she was not aware Resident #5 required assistance, incontinent care, or there were soiled linens on the floor.

During an interview conducted on 3/7/22 at 3:04 PM the AD stated she had walked down the 100 hall in the morning, and she went to the end of the hallway to say good morning to the residents at the end of the 100 hall, in room 110. She said she went back down the hall, and when she was coming back up the hall, it was then she noticed the call light was for the room Resident #5 was in.

During an interview conducted with the Administrator and the Director of Nursing (DON)

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F 550	Continued From page 5 on 3/8/22 at 3:16 PM the Administrator stated Resident #5 had some behaviors and the facility had completed a referral to psych services, and the resident had a new prescription for an anxiolytic. The DON then stated she had been informed he had thrown his soiled brief in the trash but had not seen him throw linens on the floor before. The Administrator stated for residents with behaviors, the facility staff needed to review the behaviors with the resident ' s physician, make referrals, talk to the resident ' s family, determine a baseline, care plan for the behaviors, and yesterday was the day that it was really brought to the nursing staff ' s attention about his behaviors. The Administrator further stated there were times when the NAs work together as a team, and there may not be a staff member on a hall, but the administrative staff are to make rounds and answer call lights.	F 550		