STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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
E 000	Initial Comments A recertification and complaint survey was conducted 6/13/22 through 6/16/22. The facility was found not in compliance with 483.73 Emergency Preparedness. Event ID:2OUJ11	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004		7/27/22

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

Electronically Signed | 07/04/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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
E 004	Continued From page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive emergency preparedness training program required to meet the health, safety and security needs of the resident population and staff during an emergency and or disaster situation. This failure had the potential to affect all staff and residents. Findings included: A review of the facility's Emergency Preparedness (EP) Plan occurred on 6/16/22 at 1:00 PM with the Nursing Home Administrator (NHA) and Maintenance Manager. During the review, it was discovered the plan had not been updated annually as required. The EP plan was not reviewed in the past 12 months as evidenced by a review date of 3/3/21. The communication plan was not updated with current staff contact information. The current residents' physician contact information was not updated.	E 004	E004 1. Emergency Preparedness plan was reviewed and updated by Administrator on 6/24/22. 2. Current residents are affected by this current deficiency. 3. Regional Director of Clinical Services educated Administrator the long-term care facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually on 6/24/22. 4. Administrator will audit the emergency preparedness plan to ensure accuracy quarterly x 3 months. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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
E 004	Continued From page 2 The resident risk assessment was not updated to address resident population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. In an interview on 6/15/22 at 1:00 PM with the NHA, he revealed he began employment at the facility on 6/13/22 and acknowledged the EP plan had not been reviewed and updated in the past 12 months by the previous NHA. He indicated he expected the EP manual to be reviewed and updated annually as required.	E 004		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted 6/13/22 through 6/16/22. The following complaint intakes were investigated: NC00184028, NC00185315, NC00183417, NC00189170, NC00189170, NC001189170 and NC00186864. 10 of the 25 complaint allegations were substantiated. Event ID: 2OUJ11	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	F 550		7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 550	Continued From page 3 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 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 observations, record review, family, staff and resident interviews the facility failed to treat a resident in a dignified manner by not keeping a resident ' s room clean and odor free. Resident #25 expressed feelings of embarrassment and did not want her family to visit her in her room because the room had dirty floors, missing baseboards where she had seen	F 550	F550 1. Resident #25 was moved out of room 148 to room 144 on 6/14/2022 for the room to be deep clean, baseboards replaced, and room was treated for Pest. On 6/17/2022 resident voiced satisfaction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 550	Continued From page 4 cockroaches crawling out of and a continuous strong odor. This was evident for 1 out of 4 residents reviewed for dignity. Findings included: Resident #25 was admitted to the facility on 01/03/22 with diagnoses of diabetes mellitus, chronic kidney disease, acute kidney failure, and unsteadiness on feet. Review of Resident #25 ' s quarterly Minimum Data Set (MDS) dated 04/12/22 revealed her cognition was intact, was able to communicate her needs and was occasionally incontinent of bowel and bladder. Review of Resident #25 ' s care plan dated 04/12/22 identified she required extensive one-to-two-person assistance with bed mobility, dressing, personal hygiene and toilet use. She was totally dependent on staff for bathing. An observation of Room 148 on 6/12/22 at 11:30 revealed several brown substances on the floor in front of Resident #25 ' bed. A whole was observed in the center of the floor. There was no baseboard present on Resident #25 ' s side of the room. The baseboard that was present in the room was black in color. Upon entering Room 148 there was a very strong urine odor that was present during entire observation. Additional observations of Room 148 were conducted on 6/13/22 at 1:19 pm, 6/14/22 at 10:00 am and 6/14/22 at 1:30 pm. During each of these observations there was a strong urine odor present in the room. The dark brown substances remained on the floor in front of Resident #25 ' s	F 550	of room. 2. Residents were interviewed regarding satisfaction with current room and environmental by Social Worker and designees. Completed on 6/27/22 3. Staff Development Coordinator or designee will educate current staff on satisfactory resident room and environment to include cleanliness and lack of odors and placing a work order for repairs or pest identified for the maintenance director to address. Completed by 7/27/2022. New hires will receive education on satisfactory resident room and environment to include cleanliness and lack of odors and placing a work order for repairs or pest identified for the maintenance director to address in orientation. 4. Administrator or designee will interview 3 residents per hall to ensure satisfaction with current room and environment weekly for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 550	Continued From page 5	F 550		

bed and there was a small whole in the center of the floor. Sections of the baseboard were missing and the baseboard that was present was black in color.

An observation was conducted of Room 148 on 6/14/22 at 2:30 pm with the Administrator and Corporate Representative. The Administrator and Corporate Representative indicated the room had a strong urine odor that needed to be taken care of. The Administrator stated the floorboard needed to be replaced and the entire room cleaned. Resident #25 and her roommate were temporarily moved to another room so Room 148 could be thoroughly cleaned, and repairs made.

An interview was conducted with a family member (FM) on 06/14/22 at 3:30 PM, who indicated she had visited Resident #25 on 5/15/22. The FM explained when she had visited previously, they would meet in the lobby of the facility. She continued on 5/15/22 she wanted to surprise Resident #25 and when she walked into her room she was hit with a strong odor of urine; she added it hit her in face even with her mask on. The FM indicated the room was just nasty with what looked like feces on the floor close to the resident ' s bed and a whole in the center of the floor. The FM stated the baseboard appeared to be rotten and popping off and she observed cockroaches coming out of the baseboard. She indicated Resident #25 told her the room was like this all the time. The FM stated when she left the facility, she cried all the way home because Resident #25 was a great person and did not deserve to be living in that type of environment. She stated after her visit she reported the living conditions of Resident #25 ' s room to the state.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 550	Continued From page 6 An interview was conducted with Resident #25 on 06/15/22 at 11:00 AM. Resident #25 indicated she was very glad to be in a clean room and no issues with roaches. She added she had not seen any roaches and the room and bathroom were clean. Resident #25 indicated her family could come and see her in this room and she wouldn ' t be embarrassed She added there was something wrong with her other room and the staff kept the door closed all the time. An interview was conducted with Nursing Assistant (NA) #28 who indicated she had worked with Resident #25 and was not aware the resident felt so embarrassed by her other room. She added Resident #25 never complained to her about the conditions of her room. An interview was conducted with the Administrator on 06/16/22 at 4:06pm who indicated all residents needed to be treated with dignity and respect and their rooms needed to be always clean and odor free if possible.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 7 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview the facility failed to ensure the floors in the resident ' s rooms were kept clean, free of stains and in good repair (Room 100, 103, 148, 155, 162 and 116). The facility failed to maintain the ceiling (Room 100), the resident furniture (Room 103 and 162), the window blinds (Room 111), the thermostat controls (Room 111) and the baseboard (Room 148) in good repair. The facility failed to keep the privacy curtains (Room 155 and	F 584	F584 1. Rooms 100, 103, 148, 155, 162, and 116 was cleaned, made free of stains, and placed in good repair. Room 100 ceiling was repaired. Room 103 and 162 furniture was repaired and/or replaced. Room 111 window blinds were replaced. Room 111 thermostat controls were repaired. Room 148 baseboards were replaced. Completed by 6/27/22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 8 116) and bed linens (Room 111) clean and free of stains. The facility failed to identify and resolve a strong, lingering urine odor in a resident ' s room (Room 148). Findings Included: 1.An observation of Room 100 on 6/13/22 at 10:50 am revealed the floor was very sticky. There were 2 sections on the ceiling approximately 3 to 4 feet in length over each resident bed that had brownish stains. Follow-up visits conducted on 6/14/22 and 6/15/22 of Room 100 revealed the floor remained sticky and the brownish stains remained present on the ceiling. An interview with the Maintenance Director (MD) on 6/16/22 at 1:30 pm revealed he was aware of the ceiling damage in Room 100. He stated he was trying to arrange to have the gutters cleaned and assess for any roof damage before he did the ceiling repair. An interview with the Housekeeping Director (HD) and Regional Housekeeping Director on 6/16/22 at 1:40 pm revealed the facility had 4 housekeepers per day and 2 floor technicians. The HD indicated she had some openings in the past, but all positions were full now. The HD explained she expected each resident room to be cleaned daily including emptying trash, cleaning / sanitizing bathrooms and room surfaces, low and high dusting and sweeping / mopping the floors. She added she knew some of the floors in resident ' s rooms needed more attention and to be cleaned with the buffer. The Regional Housekeeping Director stated their goal was to	F 584	2. Administrator and designees inspected residents rooms to ensure rooms were in good condition. If rooms were found in need of repairs, it was placed on the maintenance log. This process is on-going. 3. Staff Development Coordinator or designee will educate current staff on placing a work order for repairs for the maintenance director to address. Administrator in-serviced the maintenance director on repairing the rooms timely. Completed by 7/27/2022. New hires will receive education on placing a work order for repairs for the maintenance director to address in orientation. 4. Administrator and designee will audit 5 rooms per hall to ensure rooms are good repair weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 9	F 584		

schedule 2 resident rooms per week to be deep cleaned including having the floors stripped and waxed. He added the housekeeping staff were in-serviced this week on expectations for cleaning.

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.

2.An observation on 6/13/22 at 11:15 am of Room 103 revealed the bedside dresser and the built-in dresser were damaged with drawers missing. The wheelchair for Resident #37 had plastic peeling off both arm rests. The floor in the room was sticky and there were black stains present throughout the floor.

Follow-up observations of Room 103 on 6/14/22 and 6/15/22 revealed the damaged dressers with missing drawers, the same wheelchair was present with peeling plastic on the arm rests and the floor remained sticky with black stains present.

An interview with the Maintenance Director (MD) on 6/16/22 at 1:30 pm revealed he was aware of the damaged dresser drawers in room 101. He stated the resident had pulled the drawers off before and he would need to replace them again.

An interview with the Housekeeping Director and Regional Housekeeping Director on 6/16/22 at 1:40 pm revealed the facility had 4 housekeepers per day and 2 floor technicians. The HD indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 10	F 584		

she had some openings in the past, but all positions were full now. The HD explained she expected each resident room was cleaned daily including emptying trach, cleaning / sanitizing bathrooms and room surfaces, low and high dusting and sweeping / mopping the floors. She added she knew some of the floors in resident ' s rooms needed more attention and to be cleaned with the buffer. The Regional Housekeeping Director stated their goal was to schedule 2 resident rooms per week to be deep cleaned including having the floors stripped and waxed. He added the housekeeping staff were in-serviced this week on expectations for cleaning.

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.

3.An observation of Room 111 on 6/13/22 at 12:18 pm revealed the window blinds were on top of the resident ' s closet and there were no blinds present on the window. Resident #184 was present during the observations and indicated they fall off his window last week and the staff haven ' t put them back up yet.

Follow-up observations of Room 111 on 6/14/22 and 6/15/22 revealed the window blinds remained on the top of the closet.

An interview with the Maintenance Director (MD) on 6/16/22 at 1:30 pm revealed he was aware the window blinds were down in Room 111, and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 11	F 584		

would get them hung back up.

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.

4.An observation on 6/13/22 at 2:45 pm of Room 112 Bed B revealed there was a floor mat next to Resident #17 ' s bed. There was a dried dark brown circular stain present on the floor mat; approximately the size of a 50-cent piece.

A follow-up observation on 6/14/22 at 10:25 am revealed the dark brown stain remained on Resident #17 ' s floor mat.

An interview with the Housekeeping Director and Regional Housekeeping Director on 6/16/22 at 1:40 pm revealed the facility had 4 housekeepers per day and 2 floor technicians. The HD indicated she had some openings in the past, but all positions were full now. The HD explained she expected each resident room was cleaned daily including emptying trach, cleaning / sanitizing bathrooms and room surfaces, low and high dusting and sweeping / mopping the floors. She added she knew some of the floors in resident ' s rooms needed more attention and to be cleaned with the buffer. The Regional Housekeeping Director stated their goal was to schedule 2 resident rooms per week to be deep cleaned including having the floors stripped and waxed. He added the housekeeping staff were in-serviced this week on expectations for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 12	F 584		

cleaning.

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.

5.An observation of Room 112 Bed A on 6/13/22 at 3:00 pm revealed the sheets on Resident #30 ' s bed had a dried dark red stain approximately the size of a 50-cent piece. Resident #30 who was present during the observation stated sometimes he scratched his skin, and it bled onto the sheet. He added the staff did not change his sheets regularly. Resident #30 stated he would like to be able to control the temperature in his room and the thermostat hadn ' t worked in months. An observation of the thermostat revealed you could turn it on and off, but not adjust the temperature.

Follow-up observations of Room 111 on 6/14/22 at 10:20 am and 6/15/22 at 12:20 pm revealed the dried dark red stain was still present on Resident #30 ' s sheet. On 6/15/22 at 12:20 Resident #30 indicated the nursing assistant was going to change his sheet after he ate lunch.

An interview with the Administrator and Maintenance Director (MD) on 6/16/22 at 1:30 pm revealed the MD had requested 5 new thermostats from the previous Administrator and had never received them. He stated he was aware Room 111 ' s thermostat needed to be replaced. The Administrator stated he expected residents to have clean linens on their beds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 13	F 584		

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.

6.An observation of Room 148 on 6/12/22 at 11:30 revealed several brown substances on the floor in front of Resident #25 ' bed. A whole was observed in the center of the floor. There was no baseboard present on Resident #25 side of the room. The baseboard that was present in the room was black in color. Upon entering Room 148 there was a very strong urine odor that was present during entire observations.

Additional observations of Room 148 were conducted on 6/13/22 at 1:19 pm, 6/14/22 at 10:00 am and 6/14/22 at 1:30 pm. During each of these observations there was a strong urine odor present in the room. The dark brown substances remained on the floor in front of Resident #25 ' s bed and there was a small whole in the center of the floor. Sections of the baseboard were missing and the baseboard that was present was black in color.

An observation was conducted of Room 148 on 6/14/22 at 2:30 pm with the Administrator and Corporate Representative. The Administrator and Corporate Representative indicated the room had a strong urine odor that needed to be taken care of. The Administrator stated the floorboard needed to be replaced and the entire room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 14	F 584		

cleaned.

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.
7.An observation on 6/13/22 at 10:49 pm of Room 162 revealed there were papers, food crumbs and black substances on the floor throughout the entire room. One of the drawers was broken on the dresser.

An observation on 6/13/22 at 11:37 am of Room 155 revealed the floor strip entering the bathroom was missing exposing the floor. The privacy curtain for Resident #5 was noted with multiple brown, tan and orange-colored stains. Resident #5 was present in the room during the observation and indicated he had been asking for the strip to be replaced for 4 years, but it had never been done. He stated he did not know what the stains were on his privacy curtain.

Follow-up observations on 6/14/22 and 6/15/22 of Room 162 revealed paper, food particles and black stains were present on the floor. Room 155 ' s privacy curtain remained with multiple stains

An observation of Rooms 162 and 155 on 6/16/22 at 2:30 pm was conducted with the Regional Nurse Consultant. The Regional Nurse Consultant stated she had informed the staff to check the privacy curtains and she would get right on the concerns that were identified in the rooms.
An interview with the Housekeeping Director (HD)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 15	F 584		

on 6/16/22 at 1:40 pm revealed the housekeepers should check the resident ' s privacy curtains every day for stains. She added if they have spills or stains on them, they should be taken down to be washed and replaced with a clean curtain. The HD stated she kept a small number of clean privacy curtains to be used while the stained ones were being washed.

An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.

8.An observation on 6/13/22 at 11:45 am of Room 116 Bed A revealed the privacy curtain had dried brown stains running down the curtain. Resident #63 who was present during the observations stated another resident who was confused came into her room about 3 months ago and spilled her chocolate supplement shake on her privacy curtain.

A follow-up observation of Room 116 Bed A on 6/14/22 at 11:50 am revealed the privacy curtain had been cleaned with no stains noted. During these observations the floor was noted to be sticky throughout the room.

An observation on 6/16/22 at 9:48 am of Room 116 revealed there were drink wrappers and used straws on the floor. The floor was also noted to be dirty and sticky. The Housekeeping Director indicated she was short a housekeeper today on that side of the facility and she would be doing that assignment shortly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 584	Continued From page 16 An interview with the Housekeeping Director (HD) on 6/16/22 at 1:40 pm revealed the housekeepers should check the resident ' s privacy curtains every day for stains. She added if they have spills or stains on them, they should be taken down to be washed and replaced with a clean curtain. The HD stated she kept a small number of clean privacy curtains to be used while the stained ones were being washed. She added she knew some of the floors in resident ' s rooms needed more attention and to be cleaned with the buffer. The Regional Housekeeping Director stated their goal was to schedule 2 resident rooms per week to be deep cleaned including having the floors stripped and waxed. He added the housekeeping staff were in-serviced this week on expectations for cleaning. An interview with the Administrator on 6/16/22 at 4:50 pm revealed he expected the resident ' s rooms to be clean and maintained in good repair as you would your own home. He added the staff needed to utilize the maintenance reporting system in the electronic medical record system to report repair issues to maintenance.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide nail care for a resident that was dependent on staff for	F 677	F677 1. Nail care was provided for resident #17 on 6/27/22.	7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 677	Continued From page 17 provision of activities of daily living (ADLs). This was evident for 1 of 2 residents reviewed for ADL care (Resident #17). Findings Included: Resident #17 was admitted to the facility on 1/14/22 and diagnoses included contracture of the right hand. A quarterly Minimum Data Set (MDS) dated 3/2/22 for Resident #17 identified he was totally dependent on staff for personal hygiene. His cognition was severely impaired, and he had no behaviors of rejection of care during the look-back period. A care plan with a review date of 2/17/22 identified Resident #17 had an ADL (activities of daily living) self-care deficit related to bilateral upper and lower extremity contractures. Interventions included to provide extensive assistance with grooming and to check nail length, trim and clean on bath day and as necessary. An observation of Resident #17 on 6/13/22 at 2:45 pm revealed the resident ' s fingernails on his left hand were approximately 1 ½ to 2 inches in length. Some nails had dark brown substances under the nail bed. The resident ' s right hand was contracted into a fist; only a few nails on the right hand could be observed, and they were also 1 ½ to 2 inches long. An observation on 6/14/22 at 11:10 am of Resident #17 revealed the resident ' s fingernails on his left hand remained long and with some dark brown substance under the nail bed. The	F 677	2. Current residents were assessed by the Director of Nursing and designees for the need of nail care on 6/27/22 and if needed nail care was provided immediately by certified nursing assistant and/or license nurses. 3. Staff Development Coordinator or designee will educate current nursing staff on providing proper nail care for dependent residents. Completed on 7/27/2022. New hires will receive education on providing nail care for dependent residents in orientation. 4. Director of Nursing or designee will audit 5 residents per hall to ensure nail care was provided weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 677	Continued From page 18 resident ' s right hand remained in a fist position and those nails that could be observed also remained long. An interview on 6/16/22 at 11:32 with Nursing Assistant (NA) #2 revealed she was the NA for Resident #17. She stated she did trim the resident ' s nails and believed she had done this on 6/14/22. NA #2 explained she performed nail care on the residents every few days and as needed. She added Resident #17 was cooperative with care and didn ' t resist when she provided nail care. An interview on 6/16/22 at 4:45 pm with the Administrator revealed he expected residents to receive routine nail care.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 688	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to apply a splint for contracture management as recommended by therapy and ordered by the physician. This was evident for 1 of 1 resident reviewed for range of motion (Resident #17). Findings Included: Resident #17 was admitted to the facility on 1/14/22 and diagnoses included contracture of the right hand. A quarterly Minimum Data Set (MDS) dated 3/2/22 for Resident #17 identified no impairment in range of motion and his cognition was severely impaired. A care plan with an initiation date of 2/11/22 for Resident #17 identified he had an ADL (activities of daily living) self-care performance deficit related to bilateral upper / lower extremity contractures. Review of the physician ' s orders for Resident #17 revealed an order dated 5/13/22 to apply splint to right hand; ensure it is on in the AM and off in the PM. Check the skin under the brace. Review of the Occupational Therapy (OT) discharge summary dated 5/13/22 identified discharge recommendations included to wear right resting hand splint. Splint / brace program established and trained staff with splint to be worn 4 to 5 hours daily. An observation of Resident #17 on 6/13/22 at	F 688	F688 1. Resident #17 splint was applied to right hand on 6/16/2022. 2. Current recommendations from therapy and orders by the physician were reviewed by Director of Nursing and designees to identify current residents for splints to ensure application as ordered or recommended. Completed on 6/16/22 3. Staff Development Coordinator or designee will educate current nursing staff on following recommendations from therapy and orders by the physician for splint application. Completed on 7/27/2022. New hires will receive education on following recommendations from therapy and orders by the physician for splint application in orientation. 4. Director of Nursing or designee will monitor residents with splints to ensure application per recommendation or orders by physician 2x weekly for 4 weeks and weekly for 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 688	Continued From page 20	F 688		

2:45 pm revealed his right hand was contracted into a fist. There was no splint in place on the right hand.

An observation on 6/14/22 at 11:10 am of Resident #17 revealed his right hand was contracted into a fist and there was no splint in place on his right hand.

An observation on 6/15/22 at 9:26 am of Resident #17 revealed his right hand was contracted into a fist and there was no splint in place on his right hand.

Review of the treatment administration record (TAR) for Resident #17 revealed an order to apply splint to right hand in the AM and remove in the PM. The TAR for 6/13/22, 6/14/22 and 6/15/22 was signed off as being applied at 8:00 am each of these days by Nurse #3.

An interview was conducted with Nursing Assistant (NA) #2 on 6/16/22 at 11:28 am. She stated she was the NA for Resident #17 and routinely provided care for him. NA #2 indicated the resident did have a splint for his right hand, but his hand had been swelling and he hasn ' t worn the splint in several weeks. She added the nurse and therapy staff were aware of this. NA #2 stated the resident was very cooperative with care and he would let you apply the splint.

An interview on 6/16/22 at 1:30 pm with Nurse #3 revealed she had signed the TAR for splint application on 6/13/22, 6/14/22 and 6/15/22. She explained Resident #17 had an order for a splint to his right hand and therapy would apply the splint daily. Nurse #3 indicated the splint wasn ' t on when she signed the TAR today, but she wasn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 688	Continued From page 21 ' t sure if it was on when she signed the TAR on 6/13/22 and 6/14/22. She added therapy applied the splint she just signed off on the TAR. An interview on 6/16/22 at 1:50 pm with the Rehab Director (RD) revealed Resident #17 had been seen by OT and recommended / ordered a splint be worn daily on his right hand. She stated the resident has always had some swelling in the right upper extremity and the splint would help reduce the swelling. The RD added no one from therapy told nursing to not apply the splint because of swelling. She stated the therapy staff did not apply the splint; this was a nursing function once the resident was discharged from therapy. An interview on 6/16/22 at 4:55 pm with the Administrator revealed he expected splints to be applied per therapy recommendation and physician ' s orders.	F 688		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 727		7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 727	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have a Registered Nurse scheduled for 8 hours a day, 7 days a week for 5 of 32 days reviewed. (02/26/22, 05/05/22, 05/06/2), 5/07/22 and 05/27/22). Findings included: A review of the nursing schedule dated 02/26/22 and 05/01/22 through 05/30/22 revealed no Registered Nurse was scheduled on 02/26/22, 05/05/22, 05/06/22, 05/07/22, and 05/27/22. An interview conducted with the Scheduler on 06/18/22 at 2:45 pm revealed there should have been a Registered Nurse scheduled on all days missing. The Scheduler stated she worked with staff agencies to ensure coverage and that she likely overlooked the schedule for those days. An interview conducted with the former Director of Nursing on 06/18/22 at 3:09 pm stated she expected the facility to have a Registered Nurse on duty for 8 hours a day, 7 days a week. An interview conducted with the Administrator on 06/18/22 at 3:09 pm revealed he expected the facility to schedule a Registered Nurse for 8 hours per day, 7 days a week.	F 727	F727 1. Staff schedules were adjusted immediately to ensure proper RN coverage is in place. 2. Current residents are affected by this current deficiency. 3. Regional Director of Clinical Services educated the Director of Nursing and Administrator on 6/24/22 on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week. 4. Director of Nursing and/or designee will audit schedule to ensure a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 791	Continued From page 23 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 791	Continued From page 24 Based on observations, record review, resident interview, staff interview, and dental service representative interview, the facility failed to offer dental services for 1 of 2 residents (Resident #21) who had follow-up recommendations for dental services. Findings include: Resident #21 was admitted to the facility on 6/22/21. Review of Dental note dated 10/7/21 read, in part, Resident #21 was referred to an outpatient service to have tooth #32 extracted. Will follow up next visit. Future limited oral evaluation (Future indicates follow ups or treatments planned for future visits). Review of Dental note dated 11/23/21 read, in part, Resident #21 had an evaluation to see if tooth #32 had been extracted. Left PA (prior approval) for a new upper denture since patient stated they lost the upper denture. Resident #21 had no dental pain. Resident #21 ' s annual MDS (Minimum Data Set) dated 4/1/22 revealed Resident had moderate cognitive impairment. Further review of the MDS revealed Resident did not have broken, or loosely fitting dentures, cavities or broken teeth, mouth, or facial pain during the assessment period. The electronic medical record indicated Resident #21 ' s payor source was Medicaid. A review of Resident #21 ' s care plan revealed no care plan for dental issues.	F 791	F791 1. Resident #21 recommendations were reviewed on 6/16/22 to have scheduled appointment set for dental services and cleaning. Resident #21 will also be added to be seen by Aria Dental Care on the next visit. 2. Current residents recommendations were reviewed from last dental services by Director of Nursing and designees to ensure recommendations were followed up on, if recommendations were not followed through residents were set up for dental services. Completed by 6/16/22 3. Regional Director of Clinical Services educated Director of Nursing on ensuring recommendations from dental services were completed timely. Completed on 6/24/22. 4. Director of Nursing and designee will audit dental recommendations to ensure completion monthly x 3 months. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 791	Continued From page 25	F 791		

The medical record from 11/24/21 through 6/14/22 revealed no evidence of any further dental appointments for Resident #21.

An interview was conducted on 06/13/22 at 11:57 am with Resident #21 and it was indicated they had no mouth or facial pain and needed upper denture replaced due to them being misplaced while in the facility. Resident indicated it had been a "long" time since having upper dentures and wanted them replaced. Resident #21 indicated they had reported this to staff but could not remember any names.

On 06/14/22 at 4:36 PM an interview was conducted with the facility Social Worker. She was asked if Resident #21 had a follow up dental appointment to have his tooth extracted as recommended in the 10/7/21 and 11/23/21 dental notes. She indicated she was unsure if this was completed and she had to contact the facility dental service.

On 06/16/22 at 2:02 PM a follow up interview was conducted with the facility Social Worker, and she stated the facility dental service had never received the requested information from the facility for Resident #21 to receive services and had not had the follow up appointment. She indicated the plan was to move forward with the dental service to get Resident #21 the services needed. The Social Worker revealed she was new to the facility and to her knowledge there was no protocol in place for scheduling following up appointments as recommended for dental needs.

On 06/16/22 at 02:17 pm an interview was conducted with the dental service representative,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 791	Continued From page 26 and she indicated that the dental provider referred the resident for an outpatient dental visit to have the tooth extracted, but the facility had not sent in the information required to schedule the outpatient appointment. She stated the required documents for prior approval were not received from the facility and Resident #21 was not able to be seen. An interview was conducted on 06/16/22 at 4:09 PM with the facility Administrator and he indicated his expectation was for the facility to do their part and follow through with what was recommended by the dentist. He stated, "we have a new contract with the dental service and will move forward in providing the care that is needed to our residents".	F 791		
F 867 SS=E	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 observations, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 5/28/21. This was for 1 deficiency that was cited in the area of provision of activities of daily living (ADLs) for dependent residents (F677) on 5/28/21 and recited on the	F 867	F867 1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F677, F727 and F925 on 7/26/2022. 2. Current residents are affected by this	7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 867	Continued From page 27 current recertification and complaint survey of 6/16/22. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 9/27/19. This was evident for 3 deficiencies in the areas of provision of ADL care for dependent residents (F677), provide RN (Registered Nurse) coverage 8 hours a day / 7 days a week (F727) and maintain an effective pest control program (F925) originally cited on the recertification and complaint survey on 9/27/19 and recited on the current recertification and complaint survey of 6/16/22. The duplicate citations during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag was cross-referenced to: 1. F677 - Based on observations, record review and staff interview the facility failed to provide nail care for a resident that was dependent on staff for provision of activities of daily living (ADLs). This was evident for 1 of 2 residents reviewed for ADL care (Resident #17). During the recertification and complaint survey 5/28/21 the facility failed to provide nail care for a resident that was dependent for activities of daily (ADL) care. This was evident for 1 of 4 residents reviewed for ADL care (Resident #40). An interview on 6/16/22 at 3:50 pm with the Administrator revealed this was his first week at the facility. He stated he planned to have monthly quality assurance meetings with his team. He	F 867	current deficiency. 3. The Regional Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F677, F727, and F925 on 6/24/2022. 4. 7/14/2022, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Support Nurses, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 867	Continued From page 28 added he had received the corporate quality assurance forms and he would be reviewing them. The Administrator indicated he was not aware of any QAPI (quality assurance and performance improvement) plans in place at the facility. 2. F-677 - Based on observations, record review and staff interview the facility failed to provide nail care for a resident that was dependent on staff for provision of activities of daily living (ADLs). This was evident for 1 of 2 residents reviewed for ADL care (Resident #17). During the recertification and complaint survey 9/27/19 the facility failed to provide bathing for a resident that was dependent for activities of daily living (ADL) care. This was evident for 1 of 3 residents (Resident #28) reviewed for ADL care. An interview on 6/16/22 at 3:50 pm with the Administrator revealed this was his first week at the facility. He stated he planned to have monthly quality assurance meetings with his team. He added he had received the corporate quality assurance forms and he would be reviewing them. The Administrator indicated he was not aware of any QAPI (quality assurance and performance improvement) plans in place at the facility. 3. F727 - Based on record reviews and staff interviews the facility failed to have a Registered Nurse scheduled for 8 hours a day, 7 days a week for 5 of 32 days reviewed. (02/26/22, 05/05/22, 05/06/2), 5/07/22 and 05/27/22). During the recertification and complaint survey 9/27/19 the facility failed to staff Registered Nurse	F 867	facility□s progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions Compliance date: 7/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 867	Continued From page 29	F 867		

(RN) coverage for 8 consecutive hours daily during 3 out of 3 months reviewed for RN coverage (6/2019, 7/2019 and 8/2019).

An interview on 6/16/22 at 3:50 pm with the Administrator revealed this was his first week at the facility. He stated he planned to have monthly quality assurance meetings with his team. He added he had received the corporate quality assurance forms and he would be reviewing them. The Administrator indicated he was not aware of any QAPI (quality assurance and performance improvement) plans in place at the facility.

4. F925 - Based on observations, record review, resident and staff interview the facility failed to provide a pest free living environment for 8 of 91 residents residing in the facility. (Resident #58, Resident #5, Resident #25, Resident #34, Resident #49, Resident #77, Resident #10 and Resident #74)

During the recertification and complaint survey 9/27/19 the facility failed to maintain an effective pest control program (Room 127 and hallway between Room 123 and Room 127).

An interview on 6/16/22 at 3:50 pm with the Administrator revealed this was his first week at the facility. He stated he planned to have monthly quality assurance meetings with his team. He added he had received the corporate quality assurance forms and he would be reviewing them. The Administrator indicated he was not aware of any QAPI (quality assurance and performance improvement) plans in place at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 925	Continued From page 30	F 925		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide a pest free living environment for 8 of 91 residents residing in the facility. (Resident #58, Resident #5, Resident #25, Resident #34, Resident #49, Resident #77, Resident #10 and Resident #74). Findings Included: 1. During the tour on 6/13/22 at 11:11 am an observation was made of a roach crawling on the floor of Room 153. Resident #58 who was present in the room during the observation stated they were not able to see any pests due to vision problems. Review of the facility maintenance logs from January 2022 to present did not identify any pest issues for Room 153. Review of the pest control contract dated 2/5/19 revealed in part, service would be provided monthly for cockroach and rodent elimination. Insecticide could be used in vacant resident rooms upon request. Review of a pest control service report dated 6/15/22 revealed insecticide was applied to target cockroaches. This was applied to fire door introduction point, front door introduction point, interior hallways, interior kitchen area, interior	F 925	F925 1. Residents #58, #5, #25, #34, #49, #77, #10, and #74 rooms were inspected, cleaned, and treated for pest. Completed on 6/15/22 2. Facility was inspected by administrator and designees for pest sightings on 6/15/22. Pest control services will continue to treat monthly and as needed. 3. Staff Development Coordinator and designee educated staff to place work order in if pest were sighted timely. Completed on 7/27/2022. New hires will be educated on to place work order in if pest were sighted timely in orientation. 4. Administrator and designee will audit 5 rooms per hall to ensure no pest were sighted weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 7/27/2022	7/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 925	Continued From page 31	F 925		

laundry / housekeeping areas, and Room 121.

An interview on 6/16/22 at 2:30 pm with the pest control technician revealed he had been providing pest control services at the facility for a year or two. He stated he treated the facility on 6/15/22 and did not see any signs of live cockroaches. He explained he sprayed insecticide to interior areas the best he could. The technician added he could only treat a resident room if it was vacant, and he had treated room 121 on this visit. He stated the facility did not routinely request him to treat specific resident rooms. He indicated he would work with the facility to come up with a plan to eliminate pests.

An interview on 6/16/22 at 4:50 pm with the Administrator revealed he would work with their pest control technician to try and eliminate the roaches.

2. An observation of Room 155 on 06/16/22 at 9:03 am revealed a roach was crawling on the wall bedside the bathroom door.

An interview on 06/16/22 at 9:10 am with NA #1 revealed she saw roaches on occasion and would try and kill them. NA #1 added she had reported the sightings to the previous Administrator and Director of Nursing.

Review of the facility maintenance logs from January 2022 to present did not identify any pest issues for Room 155.

Review of the pest control contract dated 2/5/19 revealed in part, service would be provided monthly for cockroach and rodent elimination. Insecticide could be used in vacant resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 925	Continued From page 32	F 925		

rooms upon request.

Review of a pest control service report dated 6/15/22 revealed insecticide was applied to target cockroaches. This was applied to fire door introduction point, front door introduction point, interior hallways, interior kitchen area, interior laundry / housekeeping areas, and Room 121.

An interview on 6/16/22 at 2:30 pm with the pest control technician revealed he had been providing pest control services at the facility for a year or two. He stated he treated the facility on 6/15/22 and did not see any signs of live cockroaches. He explained he sprayed insecticide to interior areas the best he could. The technician added he could only treat a resident room if it was vacant, and he had treated room 121 on this visit. He stated the facility did not routinely request him to treat specific resident rooms. He indicated he would work with the facility to come up with a plan to eliminate pests.

An interview on 6/16/22 at 4:50 pm with the Administrator revealed he would work with their pest control technician to try and eliminate the roaches.

3.During the tour on 06/13/22 at 11:30 AM, two dead roaches were observed in the bathroom in room 148. Resident #25 who was present during the observation indicated she had observed roaches coming from the missing baseboard on her side of the room. She stated the baseboard was rotten and popping up and someone removed it, but it has never been replaced.

An interview was conducted with a family member (FM) on 06/14/22 at 3:30 PM, who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 925	Continued From page 33	F 925		

indicated she had visited Resident #25 on 5/15/22. The FM indicated she observed roaches coming out of the baseboard during her visit.

A review of the facility maintenance logs from January 2022 to present for pest control revealed no concerns for room 148.

Review of the pest control contract dated 2/5/19 revealed in part, service would be provided monthly for cockroach and rodent elimination. Insecticide could be used in vacant resident rooms upon request.

Review of a pest control service report dated 6/15/22 revealed insecticide was applied to target cockroaches. This was applied to fire door introduction point, front door introduction point, interior hallways, interior kitchen area, interior laundry / housekeeping areas, and Room 121.

An interview on 6/16/22 at 2:30 pm with the pest control technician revealed he had been providing pest control services at the facility for a year or two. He stated he treated the facility on 6/15/22 and did not see any signs of live cockroaches. He explained he sprayed insecticide to interior areas the best he could. The technician added he could only treat a resident room if it was vacant, and he had treated room 121 on this visit. He stated the facility did not routinely request him to treat specific resident rooms. He indicated he would work with the facility to come up with a plan to eliminate pests.

An interview on 6/16/22 at 4:50 pm with the Administrator revealed he would work with their pest control technician to try and eliminate the roaches.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 925	Continued From page 34	F 925		

4. A meeting was held with the facility Resident Council on 6/13/22 at 11:31 am. Resident #34, Resident #49, Resident #77, Resident #10 and Resident #74 were present. All residents present identified issues with bugs in their rooms. Resident #49 stated the facility had an issue with roaches for more than a year. She added a roach crawled on her yesterday while she was sitting in her chair. Resident #49 indicated the Administrator was aware of the issue, but they haven ' t seen any changes. All residents present agreed the facility had an issue with roaches that had not been remedied.

Review of the resident council minutes dated 5/9/22 revealed in part, a grievance was lodged during the meeting regarding pest control. The contract exterminator company was contacted and made a visit to the facility on 5/25/22.

Review of the pest control contract dated 2/5/19 revealed in part, service would be provided monthly for cockroach and rodent elimination. Insecticide could be used in vacant resident rooms upon request.

Review of a pest control service report dated 6/15/22 revealed insecticide was applied to target cockroaches. This was applied to fire door introduction point, front door introduction point, interior hallways, interior kitchen area, interior laundry / housekeeping areas, and Room 121.

An interview on 6/16/22 at 2:30 pm with the pest control technician revealed he had been providing pest control services at the facility for a year or two. He stated he treated the facility on 6/15/22 and did not see any signs of live cockroaches. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 925	Continued From page 35 explained he sprayed insecticide to interior areas the best he could. The technician added he could only treat a resident room if it was vacant, and he had treated room 121 on this visit. He stated the facility did not routinely request him to treat specific resident rooms. He indicated he would work with the facility to come up with a plan to eliminate pests. An interview on 6/16/22 at 4:50 pm with the Administrator revealed he would work with their pest control technician to try and eliminate the roaches.	F 925		