STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING ______ B. WING ______	R-C 07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	**416 N HIGHLAND STREET GASTONIA, NC 28052**

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{E 000}	Initial Comments An unannounced onsite Focused Infection Control and complaint investigation survey were conducted from 07/19/22 through 07/20/22. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 07/20/22. Tags F584, F637, F638, F640, F641, F656, F657, F692, F812, and F888 were corrected as of 07/20/22. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time of the revisit. The facility is still out of compliance. A total of 9 allegations were investigated and none were substantiated: Intakes NC00190961 and NC00189464.	{F 000}		
{F 636} SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least	{F 636}		

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

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

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{F 636}	Continued From page 1 the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no	{F 636}		

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{F 636}	Continued From page 2 significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAA) related to nutrition that addressed the underlying causes, contributing factors and risk factors as outlined in the Resident Assessment Instrument (RAI) manual for 3 of 5 sampled residents (Residents #10, #11, and #12). Findings included: 1. Resident #10 was admitted to the facility on 06/22/22 with diagnoses that included diabetes, moderate protein-calorie malnutrition, and dysphagia (difficulty swallowing). The admission Minimum Data Set (MDS) dated 06/27/22 revealed Resident #10 received a mechanically altered diet. The MDS nutrition CAA analysis of findings for Resident #10 consisted of a check list of indicators that related to functional problems that affected his ability to eat, his cognitive status, communication problems, and diseases and conditions that can affect appetite or nutritional needs. For each check list of indicators, there were no references indicating the specific date(s) or location of the relevant documentation used when completing the CAA that explained why the selected indicators were a problem for Resident #10 and no descriptive summary describing the impact of the problem on Resident #10 for care plan	{F 636}		

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{F 636}	Continued From page 3	{F 636}		

considerations. The only narrative was noted under the nature of the problem/condition which read, "Resident Body Mass Index (BMI) is 26. Resident is on a mechanically altered diet and therapeutic diet." The information did not include Resident #10's strengths, weaknesses or any specific reason these issues posed a risk to his nutritional status.

During an interview on 07/20/22 at 3:02 PM, the MDS Coordinator explained after the facility's recent recertification survey, the Dietary Manager (DM) received education on how to complete a nutrition CAA on the MDS assessment. The MDS Coordinator reviewed the nutrition CAA for Resident #10 and stated there should have been more documented related to how the problem affected Resident #10's nutritional status.

During an interview on 07/20/22 at 7:10 PM, the Director of Nursing (DON) confirmed the nutrition CAA for Resident #10 did not contain a thorough analysis of findings. The DON explained the CAA should paint a picture of the nutritional status of the resident and include relevant information to support the rationale.

2. Resident #11 was admitted to the facility on 06/22/22 with diagnoses that included hemiplegia and hemiparesis (weakness or complete paralysis on one side of the body) following cerebral infarction (stroke) affecting the right dominant side and diabetes.

The admission Minimum Data Set (MDS) dated 06/27/22 revealed Resident #11 received a mechanically altered diet. The MDS nutrition CAA analysis of findings for Resident #11 consisted of a check list of indicators that related

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{F 636}	Continued From page 4	{F 636}		

to functional problems that affected his ability to eat, his cognitive status, communication problems, diseases and conditions that can affect appetite or nutritional needs, and medications. For each check list of indicators, there were no references indicating the specific date(s) or location of the relevant documentation used when completing the CAA that explained why the selected indicators were a problem for Resident #11 and no descriptive summary describing the impact of the problem on Resident #11 for care plan considerations. The only narrative was noted under the nature of the problem/condition which read, "Resident Body Mass Index (BMI) is 27 and on a pureed textured diet." The information did not include Resident #11's strengths, weaknesses or any specific reason these issues posed a risk to his nutritional status.

During an interview on 07/20/22 at 3:02 PM, the MDS Coordinator explained after the facility's recent recertification survey, the Dietary Manager (DM) received education on how to complete a nutrition CAA on the MDS assessment. The MDS Coordinator reviewed the nutrition CAA for Resident #11 and stated there should have been more documented related to how the problem affected Resident #11's nutritional status.

During an interview on 07/20/22 at 7:10 PM, the Director of Nursing (DON) confirmed the nutrition CAA for Resident #11 did not contain a thorough analysis of findings. The DON explained the CAA should paint a picture of the nutritional status of the resident and include relevant information to support the rationale.

3. Resident #12 was admitted to the facility on 06/27/22 with diagnoses that included diabetes,

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{F 636}	Continued From page 5	{F 636}		

dysphagia (trouble swallowing), and age-related cognitive decline.

The admission Minimum Data Set (MDS) dated 06/30/22 revealed Resident #12 received a mechanically altered diet. The MDS nutrition CAA analysis of findings for Resident #12 consisted of a check list of indicators that related to functional problems that affected her ability to eat, her cognitive status, diseases and conditions that can affect appetite or nutritional needs, and medications. For each check list of indicators, there were no references indicating the specific date(s) of the relevant documentation used when completing the CAA that explained why the selected indicators were a problem for Resident #12 and no descriptive summary describing the impact of the problem on Resident #12 for care plan considerations. The only narrative was noted under the nature of the problem/condition and which read, "Body Mass Index (BMI) low or too high." The information did not include Resident #12's strengths, weaknesses or any specific reason these issues posed a risk to her nutritional status.

During an interview on 07/20/22 at 3:02 PM, the MDS Coordinator explained after the facility's recent recertification survey, the Dietary Manager (DM) received education on how to complete a nutrition CAA on the MDS assessment. The MDS Coordinator reviewed the nutrition CAA for Resident #12 and stated there should have been more documented related to how the problem affected Resident #12's nutritional status.

During an interview on 07/20/22 at 7:10 PM, the Director of Nursing (DON) confirmed the nutrition CAA for Resident #12 did not contain a thorough

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{F 636}	Continued From page 6 analysis of findings. The DON explained the CAA should paint a picture of the nutritional status of the resident and include relevant information to support the rationale.	{F 636}		
{F 695} SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to obtain a physician's order for the administration of supplemental oxygen and failed to ensure the correct flow rate was administered for 1 of 5 residents reviewed for respiratory care (Resident #13). The findings included: Resident #13 was admitted to the facility on 07/18/22 with diagnoses that included vascular dementia and pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit. The undated hospital "Patient Transitions to Facilities/Nurse to Nurse Called Report" document noted Resident #13 received supplemental oxygen at a rate of 4 Liters per Minute (LPM) via nasal cannula.	{F 695}		

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{F 695}	Continued From page 7 The Nursing Admission Screening assessment dated 07/18/22 revealed Resident #13 received supplemental oxygen via nasal cannula at a rate of 4 LPM. The Brief Interview for Mental Status assessment dated 07/18/22 revealed Resident #13 had severe cognitive impairment for daily decision making related to advanced dementia. Review of Resident #13's medical record revealed no physician's order for the administration of supplemental oxygen. An observation conducted of Resident #13 on 07/20/22 at 3:17 PM revealed she was resting in bed with no signs of distress or shortness of breath and the oxygen concentrator was placed off to the side of the bed out of her reach. The flow rate of the oxygen was set at 2 LPM and administered via nasal cannula. A subsequent observation conducted of Resident #13 on 07/20/22 at 6:22 PM revealed Resident #13's oxygen concentrator remained out of her reach with the flow rate set at 2 LPM. During an interview on 07/20/22 at 3:25 PM, the Director of Nursing (DON) confirmed Resident #13 was currently receiving supplemental oxygen at a rate of 2 LPM and there was no active physician's order for the administration of oxygen in Resident #13's medical record. The DON explained when she reviewed Resident #13's medical record, they had received report from the hospital Nurse upon her discharge that she was receiving supplemental oxygen at 4 LPM. She could not state why Resident #13's oxygen concentrator was currently set at 2 LPM and	{F 695}		

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{F 695}	Continued From page 8 explained it was likely nursing staff were trying to titrate (measure and adjust the flow rate of oxygen) her supplemental oxygen to determine how much she needed. The DON stated upon Resident #13's admission to the facility, the admitting nurse should have obtained and entered a physician's order for the administration of supplemental oxygen at the settings of 4 LPM per hospital nurse report until the physician could evaluate. During a telephone interview on 07/20/22 at 6:11 PM, the Medical Doctor (MD) stated when a resident was admitted to the facility with supplemental oxygen, he would expect for staff to continue administering the supplemental oxygen at the settings they were receiving upon their admission. The MD stated he would expect for staff to notify him and obtain an order for the administration of supplemental oxygen, LPM and titrate as tolerated.	{F 695}		