STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to make prompt efforts to resolve grievances for 1 of 3 residents sampled for grievances (Resident #11). The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severe cognitive impairment. Review of grievances revealed a grievance filed on behalf of Resident #11 dated 7/28/20. The grievance indicated concerns related to weight loss, hair loss and the facility's failure to communicate changes to the family. There was no investigation noted on the grievance report nor resolution communicated to the resident or family. An interview was conducted with the Regional Director of Operations on 9/2/20 at 12:30 PM who stated the former Administrator was the grievance official. She stated it was the former Administrator's responsibility to ensure grievances were investigated and resolution was communicated to the responsible party. The Regional Director of Operations stated she did not know why this grievance for Resident #11 was not investigated. An interview was conducted with the Director of Nursing on 9/2/20 at 1:46 PM who stated she had no contact with Resident #11's family regarding a grievance. An interview was conducted with the Social Work Assistant on 9/3/20 at 11:12 AM who stated she was aware the Social Worker took the grievance from a family member. She stated she recalled that this grievance was brought up in the daily morning meeting but was unsure of any investigation completed for the grievance. The Social Worker was unavailable for interview.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to invite the resident representative to the care plan conference for 1 of 3 sampled residents (Resident #11). The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severe cognitive impairment. The medical record revealed no interdisplinary care conference was held since 4/28/20. An interview was conducted with the Social Work Assistant on 9/2/20 at 11:12 AM who stated the social work department invited residents or resident representatives to care conferences. She stated that since March 2020 care plan conferences were held over the phone. The Social Work Assistant stated Resident #11 had not had a care plan conference since 4/28/20. She reported that a care plan conference should have been conducted. An interview was conducted with MDS Nurse #1 on 9/2/20 at 11:40 AM who stated the care conference was not completed and it must have been an oversight. She reported she would contact the resident representative to conduct a care conference. During an interview with the Regional Director of Operations on 9/2/20 at 1:32 PM she indicated the care plan conference for Resident #11 should have been conducted quarterly.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and physician interviews the facility failed to prevent weight loss for 1 of 1 resident reviewed for weight loss (Resident #11). The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#11 to receive a frozen supplement each day to increase calorie intake. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severe cognitive impairment and had experienced weight loss. A nutrition note dated 7/17/20, written by the facility ' s RD, revealed a recommendation for Resident #11 to receive a frozen supplement each day to increase calorie intake and noted it was a previous recommendation. Resident #11 ' s care plan, most recently reviewed on 7/20/20 identified: weight loss due to poor appetite and intake. Approaches to this problem included registered dietician to evaluate and make diet change recommendations as needed. Resident #11 ' s weight record from May 07, 2020 to August 06, 2020 revealed the resident had experienced the following weight loss: 05/07/20: 120 pounds 06/11/20: 117 pounds 07/07/20: 112 pounds 08/06/20: 110 pounds A nutrition note dated 8/13/20 written by the facility ' s RD, revealed a recommendation for for Resident #11 to receive a frozen supplement each day to increase calorie intake and noted it was a previous recommendation. An interview was conducted on 09/03/20 at 2:54 PM, with the facility ' s Registered Dietitian who made previous recommendations for Resident #11 to have a frozen nutritional supplement daily. The RD reported that she had been providing consultation remotely to the facility since May 2020. The Registered Dietician stated she made recommendations and would email them to the Director of Nursing (DON). She indicated Resident #11 ' s name sounded familiar but could not recall the situation. The Registered Dietician stated that she had no contact with the physician and the DON was responsible for speaking with the doctor about her recommendations. An interview was completed with the facility ' s former Director of Nursing (DON) on 9/4/20 at 1:28 PM. She stated that when the Registered Dietician made recommendations they would be sent to her via email. She reported that she did not have an opportunity to take the recommendations and speak with the doctor. She reported she was the only person in the facility getting the dietary recommendations and she didn ' t have time because of staffing. The former DON stated she frequently had to work on a medication cart and the RD ' s recommendations were not addressed. An interview was conducted with the facility ' s current Director of Nursing on 9/4/20 at 1:53 PM. The current DON stated dietary recommendations should be reviewed and addressed by the DON or designee. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He stated he was aware Resident #11 had lost weight in the past but not recently. He reported the facility had not contacted him regarding adding a frozen supplement for Resident #11. The Medical Director stated the facility would not need to contact him to add a frozen supplement to Resident #11 ' s diet if recommended by the Registered Dietician.
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and physician interviews the facility failed to ensure physician visits were performed every sixty days as required for 2 of 3 sampled residents reviewed for physician services (Resident #1 and Resident #11). The findings included: 1. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The medical record revealed physician progress notes [REDACTED]. During an interview on 9/3/20 at 1:45 PM the Regional Vice President stated the nurse practitioner was not submitting her notes, so she was terminated from the facility approximately the first week of April. She further stated the current medical director is in the facility frequently seeing patients but may not be documenting visits. During an interview on 9/9/20 at 8:01 AM the Director of Nursing reported the medical records director was responsible for scheduling doctor ' s visits and ensuring the provider ' s note was uploaded into the

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

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F 0712 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) chart. She indicated Resident #1 should have been seen by a provider between 2/12/20 and 7/13/20 and the notes filed in the electronic medical record. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He indicated Resident #1 was now being seeing by a provider in his practice and was seen previously by another provider. 2. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The medical record revealed the most recent physician progress notes [REDACTED]. During an interview on 9/3/20 at 1:45 PM the Regional Vice President stated the nurse practitioner was not submitting her notes, so she was terminated from the facility approximately the first week of April. She further stated the current medical director is in the facility frequently seeing patients but may not be documenting visits. During an interview on 9/9/20 at 8:01 AM the Director of Nursing reported the medical records director was responsible for scheduling doctor 's visits and ensuring the provider"s note was uploaded into the chart. She indicated Resident #11 should have been seen by a provider since 3/19/20 and filed into the electronic medical record. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He indicated Resident #11 was his patient. He stated that he did not recall the last time he saw Resident #11 and she may have been seen by another provider in his practice.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and physician interview the facility failed to ensure the physician reviewed pharmacy recommendations and documented any action taken or a rationale for no action taken on the pharmacy request for 1 of 1 resident reviewed for drug regimen review (Resident #11). The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had severe cognitive impairment. Review of Resident #11 ' s orders revealed on 12/21/19 she was ordered [MEDICATION NAME] 15 milligrams by mouth at bedtime for depression. Resident #11 was ordered [MEDICATION NAME] .5 milligrams as needed for acute anxiety and agitation on 5/20/20 with an indefinite end date. Resident #11 last received Miratzapine 15 milligrams on 9/6/20 and [MEDICATION NAME] .5 milligrams on 8/23/20. Record review revealed a consultant pharmacy report dated 6/11/20 with a recommendation to consider a dose reduction of [MEDICATION NAME] to 7.5 milligrams from 15 milligrams. There was no documentation of any action taken or a rationale for no action taken. Record review revealed a consultant pharmacy report dated 7/9/20 with a recommendation to either discontinue the as needed order for [MEDICATION NAME] or indicate a stop date for the medication. There was no documentation of any action taken or a rationale for no action. Record review revealed a consultant pharmacy report dated 8/7/20 with a recommendation to either discontinue the as needed order for [MEDICATION NAME] or indicate a stop date for the medication. An interview was completed with the former Director of Nursing on 9/4/20 at 1:28 PM. She indicated the monthly consultant pharmacy reports were sent to her via email. She reported that she did not have an opportunity to take the recommendations and speak with the doctor. She reported she was the only person in the facility getting these reports and she didn ' t have time to follow-up on these reports because of staffing. The former DON stated she frequently had to work on a medication cart and the pharmacy recommendations were not addressed. An interview was conducted with the current Director of Nursing on 9/4/20 at 1:53 PM who stated the consultant pharmacy recommendations should be reviewed and addressed by the DON or designee. An interview was conducted with the Medical Director on 9/4/20 at 3:39 PM. He indicated he was not aware of any consultant pharmacy recommendations. The Medical Director stated he was unaware that Resident #11 was taking as needed [MEDICATION NAME] as that is not a drug he utilized.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident, staff, and physician interview, the facility failed to monitor resident vital signs according to Centers for Disease Control and Prevention (CDC) guidelines, post signage related to Coronavirus disease 2019 (COVID-19), ensure hand hygiene was performed by staff and visitors during entrance screening process, cancel resident's group activities, and notify cognitively intact residents who were their own responsible party of COVID-19 test results. (Resident #2, #4, #6, #9, and #10) This failure occurred during a COVID-19 pandemic. Findings included: 1. Per CDC guidelines titled Responding to Coronavirus (COVID-19) in Nursing Homes updated [DATE] read in part Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Per CDC guidelines titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated [DATE] read in part While screening should be performed upon entry to the facility, it should also be incorporated into daily assessments of all admitted patients. The facility's COVID Response Plan updated [DATE] read in part COVID positive or exposed, isolated residents are monitored very close for change in condition that may warrant hospitalization . Moved to every 4 hours vitals and SPO2 (oxygen saturation). The facility's COVID Response Plan updated [DATE] read in part All residents in center receiving every shift temperature monitoring, SPO2 every shift, and respiratory surveillance daily. a. Resident #4: Record review of Resident #4 revealed she was sent to the hospital on [DATE] and returned to the facility from the hospital on [DATE] and died on [DATE]. During that time documentation revealed her temperature and oxygen saturation had been taken on [DATE] at 9:19 PM and [DATE] at 2:02 PM. Resident #4 tested negative for COVID-19 at the facility on [DATE] and positive for COVID-19 at the hospital on [DATE]. Record review of progress notes and assessment records reveal no documentation of a respiratory assessment in the month of August. An interview with Nursing Assistant (NA) #1 on [DATE] at 2:15 PM revealed she had worked some of the day and evening shifts on the COVID-19 unit between [DATE] and [DATE] and had provided care to Resident #4. She stated the nurse had told her not to worry about taking Resident #4's vital signs which she understood to mean the nurse would take them. An interview with NA #2 on [DATE] at 3:15 PM revealed she worked some of the evening shifts on the COVID-19 unit between [DATE] and [DATE] and had provided care to Resident #4. She stated she didn't remember if she had taken her vital signs or not but if she had taken them she would have documented them in the computer. She further stated the nurse had probably taken Resident #4's vital signs. An interview with Nurse #3 on [DATE] at 12:05 PM revealed she had worked on the COVID-19 unit at least one day between [DATE] and [DATE]. She stated she did not take Resident's #4's vital signs because there was no order for her to do so. Attempts to contact the agency staffing nurse on duty on [DATE] when Resident #4 died were unsuccessful. b. Resident #2: Record review of Resident #2 revealed she was sent to the hospital for evaluation on [DATE] and returned to the facility on [DATE]. Resident #2 tested negative for COVID-19 at the facility on [DATE] and positive for COVID-19 at the hospital on [DATE]. Record review revealed Resident #2's temperature had been taken 5 times in the month of August. Twice on [DATE] and daily on [DATE], [DATE], and [DATE]. Record review revealed Resident #2's oxygen saturation had been taken once in the month of August on [DATE]. Record review of progress notes and assessment records reveal no documentation of a respiratory assessment in the month of August. c. Resident #6: Resident #6 tested negative for COVID-19 at the facility on [DATE] and tested positive for COVID-19 at the hospital. Record review of Resident #6 revealed he was sent to the hospital for evaluation on [DATE] and died at the hospital on [DATE]. Record review revealed Resident #6's temperature had been taken 4 times in the month of August. Once on [DATE], twice on [DATE] and once on [DATE]. On [DATE] at 7:49 PM he had a temperature of 102.1 and on [DATE] at 10:52 PM his temperature was 100.8. Record review revealed Resident #6's oxygen saturation had been taken once in the month of August on [DATE] at 6:26 PM and was 87% at that time. Record review of progress notes and assessment records reveal no documentation of a respiratory assessment in August. An interview with the Medical Director on [DATE] at 3:39 PM revealed he was unaware residents were not being assessed and monitored at least daily. He stated there were protocols in place to monitor all facility residents. He stated all COVID positive residents should have temperature, oxygen saturation, and lung assessment at least every ,[DATE] hours. He further stated he or the on-call physician should be notified for any abnormal vital signs or respiratory assessments. He stated it was not appropriate for the facility not to monitor COVID positive resident at least every ,[DATE] hours. An interview with the Director of Nursing (DON) on [DATE] at 4:13 PM revealed she was unaware residents' temperature, oxygen saturation, and lung assessments were not being done daily on all non-COVID residents and three times per day on COVID positive residents. An interview with the Interim Administrator and Regional Director of Operations on [DATE] at 11:45 AM revealed they were unaware vital signs including temperature, oxygen saturation and respiratory assessments were not being done every 4 hours for COVID positive residents and every shift for non COVID positive residents. They did not know why this was not being done. 2. CDC guidelines titled Preparing for COVID-19 in Nursing Homes updated [DATE] read in part Post signs at the entrances to the facility advising visitors to

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) check-in with the front desk to be assessed for symptoms prior to entry. Observations on arrival to the facility on [DATE] at 9:00 AM revealed the unlocked facility main entrance had no signage posted at entrance related to entrance check-in, infection prevention contact precautions, wearing Personal Protective Equipment (PPE), or visitor restrictions. Observations on arrival to the facility on [DATE] at 9:15 AM revealed the unlocked facility main entrance had no signage posted related to entrance check-in, contact precautions, wearing PPE, or visitor restrictions. CDC guidelines titled Responding to the Coronavirus (COVID-19) in Nursing Homes updated [DATE] read in part Place signage at the entrance to the COVID-19 care unit that instructs HCP (Health Care Personnel) they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. Observations on [DATE] at 3:15 PM and [DATE] at 12:59 PM of the entrance of the designated COVID-19 area revealed no signage posted related to COVID-19, infection prevention contact precautions, visitors, or PPE. Observations inside the COVID-19 unit on [DATE] at 3:18 PM and [DATE] at 1:00 PM on the second set of entry doors revealed no signage posted related to infection prevention contact precautions, PPE, or COVID-19 except for a diagram of how to put on and take off PPE which was taped to an interior window by the PPE storage. Observations inside the COVID-19 unit on [DATE] at 3:30 PM revealed no signage posted related to PPE or infection prevention contact precautions was posted on the resident's room doors. An interview and observation with the Director of Nursing (DON) on [DATE] at 12:45 PM revealed the facility main entrance door was unlocked, had no PPE sign or visitor restriction sign. The COVID-19 entrance door had no signs of any type, the second set of entry doors in the COVID-19 area had no signs of any type. The DON stated she was unaware there were no signs posted on the facility entrance or COVID-19 area related to PPE and infection prevention precautions. She stated there should be infection prevention and PPE signage at all entry points. An interview with the Interim Administrator and Regional Director of Operations on [DATE] at 11:45 AM revealed they believed there were PPE and visitor restrictions signs were in place on the facility main entrance door. They were unaware if the COVID-19 area had any contact precaution or PPE signs. They did not know why this was not done. 3. During the screening process to enter the facility on [DATE] at 9:00 AM, two of the two state surveyors were not required to perform hand hygiene. Observation on [DATE] at 9:00 AM of the entrance screening process for two employees revealed no hand hygiene was encouraged or verified. During the screening process to enter the facility on [DATE] at 9:00 AM and on [DATE] at 9:15 AM, two of the two state surveyors completed the screening questionnaire. Staff were not observed to review the completed questionnaire. Observations during this investigation revealed a hand sanitizer dispenser at the facility entrance. An interview with Nurse #1 on [DATE] at 10:35 AM revealed she took her own temperature and answered the questionnaire on entrance to the facility. She also revealed she had not seen anyone review her temperature or completed questionnaire. An interview with Nurse #2 on [DATE] at 10:59 AM revealed she had never seen anyone review the entrance questionnaire answers and she was unaware if they were reviewed. An interview with the Director of Nursing (DON) on [DATE] at 4:13 PM revealed she was unaware the facility had not required hand hygiene to be performed. She stated she expected all visitors and staff to be screened and perform hand hygiene prior to entering resident care areas. She further stated she reviewed the entrance questionnaire form to ensure it was completed and did not evaluate the answers to ensure staff had no signs or symptoms of COVID-19. An interview with the Interim Administrator and Regional Director of Operations on [DATE] at 11:45 AM revealed they were unaware hand hygiene was not required on entrance to the facility or if the completed questionnaire was reviewed. They did not know why this was not being done. 4. CDC guidelines titled Preparing for COVID-19 in Nursing Homes updated [DATE] read in part Cancel communal dining and group activities, such as internal and external activities. The facility's COVID Response Plan updated [DATE] read in part No communal dining and no group activities outside of resident rooms except out of doors with 6' minimum distance between residents and required masks. An interview with the Activities Director on [DATE] at 2:44 PM revealed the Resident Council meeting had been held in the West Annex dining room for July and August. She stated she asked the Administrator for and was given permission to gather residents for the meeting. She stated 10 residents attended the [DATE] meeting and 7 residents attended the [DATE] meeting. She stated they had placed the residents 6 feet apart during the meeting. The Activities Director also stated that due to the current COVID-19 outbreak, the September Resident Council meeting will be done individually by going to resident rooms. An interview with the Director of Nursing (DON) on [DATE] at 4:13 PM revealed she was not the DON when the facility held a group Resident Council meeting and was not aware this had occurred. She also revealed the facility should not have group activities due to the COVID-19 pandemic. An interview with the Interim Administrator and Regional Director of Operations on [DATE] at 11:45 AM revealed they were unaware the facility had held group activities in July and August. They did not know why this was done. 5. Per CDC guidelines title Responding to Coronavirus (COVID-19) in Nursing Homes updated [DATE], read in part Promptly (within 12 hours) notify HCP (Health Care Personnel), residents and families about identification of COVID-19 in the facility. It also read in part Maintain ongoing, frequent communication with residents, families and HCP with updates on the situation and facility actions. Record review of Resident #9's most recent Minimum Data Set ((MDS) dated [DATE] indicated he was cognitively intact. Record review of Resident #9's resident profile indicated he was his own responsible party. An interview with Resident #9 on [DATE] at 12:45 PM revealed he had been tested for COVID-19 and stated he had not been informed of the results. Record review of Resident #10's most recent MDS dated [DATE] indicated he was cognitively intact. Record review of Resident #10's resident profile indicated he was his own responsible party. An interview with Resident #10 on [DATE] at 10:56 AM revealed he had been tested 4 times for COVID-19 and had not been informed of the results. An interview with the Director of Nursing (DON) on [DATE] at 4:13 PM revealed she performed the COVID-19 testing on the residents. She stated, I told the residents she only tested residents who were not positive. An interview with the Interim Administrator and Regional Director of Operations on [DATE] at 11:45 AM revealed they were unaware if the residents had been informed of their test results.