STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT MIDWOOD, LLC	**2727 SHAMROCK DRIVE CHARLOTTE, NC 28205**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, nursing staff interviews and medical providers interviews, the facility failed to notify the resident's responsible party and the facility's medical providers regarding an opened wound on a resident's foot for 1 of 3 residents reviewed for notification of significant changes (Resident #1). Resident #1 was readmitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. Resident #1 transferred to the hospital on [DATE] and was discharged from the facility. Resident #1's last quarterly Minimum Data Set ((MDS) dated [DATE] revealed that she was severely cognitively impaired. She was dependent on one person providing activities of daily, specifically personal hygiene. The MDS also identified Resident #1 was 2 persons assist with bed mobility and transfers. The MDS indicated she was at risk for pressure ulcers but had none at the time of the assessment. The MDS identified Resident #1's weight to be 72 pounds. Resident #1's care plan updated 8/3/2020 included focus areas for activities of daily living (ADL) self-care performance deficit, behavior problem related to refusing ADL care, at risk for further pressure ulcer development, and resident has wound infection of right lateral foot (initiated 8/11/20) with a goal that resident will be free of infection and interventions to administer antibiotics as ordered by provider. . A record review of Resident#1 progress notes included Nurse #3's documentation dated 7/28/2020 and timed 5:05 PM. The note indicated a nurse aide informed this writer of new open area to Resident's (Resident #1) right inner foot. Area cleaned and dressed. Wound care nurse and hall nurse notified. An interview was conducted on 8/24/2020 at 2:52 PM with NA #4. She stated while assisting Resident #1 with a shower on 7/28/2020, she observed a small sore on the side of her right foot. NA #4 stated she informed the floor nurse assigned to Resident #1 and Nurse #3 on the same day. She was not able to identify who the assigned floor nurse was at the time of the interview. NA #4 reported she observed a dressing on Resident #1's right foot on the following day. On 8/24/2020 at 2:41 PM, an interview was conducted with Nurse #3. Nurse #3 reported that she was notified by NA #4 that Resident #1 had an open skin area on her right foot on 7/28/20. During the interview, Nurse #3 described the open skin area by stating the area looked like a blister that had ruptured at some point, no redness or swelling, no skin flap from possible rupture. She also stated she did not notify Resident #1's responsible party, or a facility provider of her observation or receive treatment orders from a provider. Nurse #3 reported she wrote a note on a piece of paper informing Nurse #2 of her observation of Resident #1's skin/open wound on her right foot and what she did to dress the wound. Nurse #3 stated she left the piece of paper in Nurse #2's box for her to review on the next day. Nurse #3 stated she thought she also had informed Nurse #2 verbally of her observation and how she had dressed the open wound of Resident #1 on the day following 7/28/2020 She also stated NA #4 informed her that she had informed the floor nurse. Nurse #3 stated she expected the floor nurse (whom she was unable to identify) to have informed Resident #1's responsible party and the facility's medical provider. Nurse #3 acknowledged she should have confirmed the facility's medical provider had been informed or she should have informed the facility's medical provider of her observation and care provided for Resident #1's open wound. On 8/24/2020 at 5:30PM during a phone interview with Nurse #5, he recalled completing the skin review for Resident #1 early in the day shift (7:00AM - 3:00PM) on 7/28/20. Nurse #5 stated he performed a head to toe skin assessment with assigned residents when completing a weekly skin review. He stated he did not identify concerns or observe skin breakdown or any open areas on Resident #1's right foot. Nurse #5 was not able to recall if he had been informed by a nurse aide or Nurse #3 that Resident #1 had an open wound on her right foot on 07/28/20. An interview was conducted on with the facility's wound nurse, Nurse #2, on 8/24/2020 at 2:30PM. During the interview with Nurse #2, she reported having no knowledge of, nor had received written or verbal communication any skin breakdown for Resident #1 prior to her observation on 8/10/2020. An interview with the Director of Nursing (DON) was conducted on 8/24/2020 at 3:45PM. The DON stated her expectation was for all nurses to complete a risk management assessment and notify the facility's medical providers of observations of changes in skin condition. The DON also stated Nurse #3 should have completed the risk management assessment on 7/28/2020 and notified Resident #1's responsible party and the facility's medical provider of Resident #1's new area of skin breakdown observed on 7/28/20. An interview with the facility's Nurse Practitioner on 8/25/2020 at 3:41 PM, NP #1 stated she expected to be notified of any new open skin areas observed by nursing staff. NP #1 stated she would have expected Nurse #3 to have contacted a facility provider on 7/28/20 regarding Resident #1's new open skin area on her right foot. On 8/25/2020 at 3:48PM, during an interview with the facility's medical director, he stated facility nurses should call to inform the facility providers of new open skin areas. He would have expected Nurse #3 to contact a facility provider on 7/28/20 regarding Resident #1's new open skin area on her right foot.
F 0600 **Level of harm -** Actual harm **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, nursing staff interviews and medical providers interviews, the facility neglected to communicate. accurately track, document, assess and initiate medical treatment for [REDACTED]. The resident was transferred to the hospital and was observed with a necrotic open foul-smelling wound on her lateral right foot with tendons exposed on her right fifth toe (Resident #1). The findings included: Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A weekly skin review/assessment was completed by Nurse #5 on 7/28/20 and indicated Resident #1's skin was intact. On 8/24/2020 at 5:30PM during a phone interview with Nurse # 5 stated he performed a head to toe skin assessment with assigned residents when completing a weekly skin review. On 7/28/2020, he recalled completing the skin review for Resident #1 early in the day shift (7:00AM - 3:00PM). He stated that he did not identify concerns or observe skin breakdown or any open areas on Resident #1's right foot. Nurse #5 was not able to recall if he had been informed by a nurse aide that Resident #1 had an open wound on her right foot on 07/28/20. A progress note for Resident #1 written by Nurse #3 on 7/28/2020 and timed at 5:05 PM specified a nursing assistant (NA) informed Nurse #3, unit manager, of a new open area to the resident's right inner foot. The note also specified the area was cleaned and dressed and the wound care nurse and hall nurse were notified. An interview was conducted on 8/24/2020 at 2:52 PM with NA #4. She stated while assisting Resident #1 with a shower on 7/28/2020, she observed a small sore on the side of her right foot. NA #4 stated she informed the floor nurse assigned to Resident #1 and Nurse #3 on the same day. She was not able to identify who the assigned floor nurse was at the time of the interview. NA #4 reported she observed a dressing on Resident #1's right foot on the following day. NA #4 stated after 7/29/2020 she did not observe any skin changes or dressings on Resident #1's right foot. On 8/24/2020 at 2:41 PM, an interview was conducted with Nurse #3. Nurse #3 reported that she was notified by NA #4 that Resident #1 had an

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 1) open skin area on her right foot on 7/28/20. During the interview, Nurse #3 described the open skin area by stating the area looked like a blister that had ruptured at some point, no redness or swelling, no skin flap from possible rupture. She also stated the open skin area was red and beefy with clear drainage, maybe quarter sized. Nurse #3 reported she cleaned the open wound with an enzymatic [MEDICATION NAME] ointment, a sterile non-adhesive protective dressing and a gauze bandage roll. Nurse #3 could not explain why she did not document her observations of the wound on 7/28/20. She also stated she did not notify Resident #1's responsible party, or a facility provider of her observation or receive treatment orders from a provider. Nurse #3 reported she wrote a note on a piece of paper informing Nurse #2 of her observation of Resident #1's skin/open wound on her right foot and what she did to dress the wound. Nurse #3 stated she left a piece of paper in Nurse #2's box for her to review on 7/29/20. Nurse #3 reported this method of communication was used to inform the facility's wound nurse, Nurse #2, of observations of changes in skin condition, any new orders obtained, and treatment provided by the nurse. Nurse #3 indicated she thought she had informed Nurse #2 on 7/29/20 verbally of her observation and how she had dressed the open wound of Resident #1. Nurse #3 stated she assumed Nurse #2 found the piece of paper in her box. She stated NA #4 informed her that she also had informed the floor nurse. Nurse #3 stated she expected the floor nurse to have informed Resident #1's responsible party and the facility's medical provider of what been reported to him. Nurse #3 acknowledged she should have confirmed the facility's medical provider had been informed or she should have informed the facility's medical provider of her observation and care provided for Resident #1's open wound. Nurse #3 also acknowledged she should have received treatment orders by the provider on 07/28/20, prior to using an enzymatic [MEDICATION NAME] ointment on Resident #1's right foot open wound. Resident #1's quarterly Minimum Data Set ((MDS) dated [DATE], revealed she was severely cognitively impaired, dependent on one person for activities of daily living, including personal hygiene. The MDS also identified Resident #1 was 2 persons assist with bed mobility and transfers. The MDS indicated she was at risk for pressure ulcers, but no pressure sores were present at the time of the assessment. The MDS identified Resident #1's weight to be 72 pounds. Resident #1's care plan updated 8/3/2020 included focus areas for activities of daily living (ADL) self-care performance deficit, behavior problem related to refusing ADL care, at risk for further pressure ulcer development, and resident has wound infection of right lateral foot (initiated 8/11/20) with a goal that resident will be free of infection and interventions to administer antibiotics as ordered by provider. A weekly skin review/assessment was completed by Nurse #4 on 8/04/2020 and noted Resident #1 had preexisting dry skin. No open areas were documented. On 8/25/2020 at 10:30 AM during a phone interview Nurse #4 could not recall what had been observed on Resident #1's 8/04/2020 weekly skin review/assessment other than what had been documented. A weekly skin review/assessment was completed by Nurse #2 on 8/10/2020 and indicated Resident #1 new open area/right lateral foot pressure ulcer. There were no measurements or further description of the area included on the skin assessment. An interview was conducted with the facility's wound nurse, Nurse #2, on 8/20/2020 at 11:30 AM. Nurse #2 reported she has completed weekly skin review/assessments when the floor nurse had not been able to complete the task. On 8/10/2020, she completed the skin review for Resident #1 and observed a small open wound close to her toes on her right foot. She notified Resident #1's responsible party, a family member, of her observation and contacted Nurse Practitioner (NP) #1 and received telephone orders for an antibiotic and treatment orders. On 8/11/2020, she observed sloughing of the wound. Nurse #2 indicated another family member contacted the facility on 8/12/2020 and requested Resident #1 be transferred to the hospital. Nurse #2 reported she observed no signs of gangrene or foul odor from the wound prior to Resident #1 discharge from the facility. Also, during the interview with Nurse #2, she reported having no knowledge of, nor had received written or verbal communication of any skin breakdown for Resident #1 prior to her observation on 8/10/2020. Record review of Resident #1's August 2020 medication and treatment administration records revealed nurse practitioner/physician telephone orders dated 8/11/2020 included an order for [REDACTED]. Resident to wear a protective boot at all times. The facility's hospital transfer summary sheet dated 8/12/20 at 6:24 PM indicated Resident #1 was afebrile and her vital signs were within normal limits. The document noted a skin wound or ulcer. Skin status evaluation - pressure ulcer/injury. Resident #1's hospital admission record dated 8/12/2020, revealed, the chief complaint noted was a wound on the resident's right foot. On physical exam, Resident#1 was afebrile, awake, alert and in no apparent distress. Resident#1 was noted to present with a necrotic open foul-smelling wound on her lateral right foot with tendons exposed on her right fifth toe. The right fifth toe was noted to be necrotic and she had skin changes overlying the plantar and dorsal surface of the foot suggesting the ulcer had been there for quite some time. Resident#1 did have palpable pulses in the right foot. No [MEDICAL CONDITION] (infection). Orthopedics was consulted at a nearby sister hospital and the resident was transferred there and had a right [MEDICAL CONDITION] on 8/14/20. An interview with the Director of Nursing (DON) was conducted on 8/24/2020 at 3:45 PM. The DON stated her expectation was for all nurses to complete a risk management assessment and notify the facility's medical providers of observations of changes in skin condition. The DON also stated Nurse #3 should have completed the risk management assessment on 7/28/2020 and notified Resident #1's responsible party, the facility's medical provider to obtain treatment orders for nursing staff to provide care for Resident #1's new area of skin breakdown. During an interview on 8/25/2020 at 3:41 PM the facility's nurse practitioner (NP #1) confirmed she was notified by phone from Nurse #2 of an open wound on Resident #1's right foot while performing a weekly skin review. NP #1 did not assess Resident #1's new open wound virtually. NP #1 also stated in her professional opinion, a wound deterioration was most likely over a course of days. NP #1 stated based on Resident #1's medical history including chronic malnutrition, she was at risk for skin breakdown. On 8/25/2020 at 3:48 PM an interview was conducted with the facility's medical director. He stated nurses should call to inform facility providers of new open skin areas in order to obtain treatment orders. The Physician reported Resident #1 was a risk for tendon exposure due to her comorbidities and adult failure to thrive. Regarding the hospital admission summary, the Physician stated gangrene can occur rapidly, over a few days. He also stated gradual discoloration could not be noticed right away and could have been overlooked by the nursing staff providing bathing, showering and skin care. Based on the description of the wound on 7/28/2020, the Physician stated the open wound sounded like a blister that erupted. He also stated the hospital records noted pulses in her lower extremities, therefore, he would not have expected a rapid deterioration of skin breakdown. The Physician stated with DTI (deep tissue injury) the tissue damage was not fast; the visualization of skin breakdown was rapid. The Physician concluded by stating the condition of Resident #1's skin had the potential for skin breakdown and was virtually unavoidable because of her risk factors. The Physician stated Resident #1 should have been followed by the wound nurse on a regular basis when the open foot wound was observed on 7/28/2020.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and staff interviews the facility failed to accurately code a quarterly Minimum Data Set Assessment (MDS) for an opened area on a resident's foot for 1 of 3 sampled residents reviewed for providing care according to professional standards (Resident #1). The findings included: Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A progress note for Resident #1 written by Nurse #3 on 7/28/2020 and timed at 5:05 PM specified a nursing assistant (NA) informed Nurse #3, unit manager, of a new open area to the resident's right inner foot. The note also specified the area was cleaned and dressed and the wound care nurse and hall nurse were notified. An interview was conducted on 8/24/2020 at 2:52 PM with NA #4. She stated while assisting Resident #1 with a shower on 7/28/2020, she observed a small sore on the side of her right foot. NA #4 stated she informed the floor nurse assigned to Resident #1 and Nurse #3 on the same day. She was not able to identify who the assigned floor nurse was at the time of the interview. NA #4 reported she observed a dressing on Resident #1's right foot on the following day. NA #4 stated after 7/29/2020 she did not observe any skin changes or dressings on Resident #1's right foot. On 8/24/2020 at 2:41 PM, an interview was conducted with Nurse #3. Nurse #3 reported that she was notified by NA #4 that Resident #1 had an open skin area on her right foot on 7/28/20. During the interview, Nurse #3 described the open skin area by stating the area looked like a blister that had ruptured at some point, no redness or swelling, no skin flap from possible rupture. She also stated the open skin area was red and beefy with clear drainage, maybe quarter sized. Resident #1's quarterly Minimum Data Set ((MDS) dated [DATE], revealed she was severely cognitively impaired, dependent on one person for activities of daily living, including personal hygiene. The MDS also identified Resident #1 was 2 persons assist with bed mobility and transfers. The MDS indicated she was at risk for pressure ulcers, but no pressure sores were present at the time of the assessment. The MDS identified Resident #1's weight to be 72 pounds. Section M1040 was not coded to reflect the opened area on her right foot.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Based on observation, staff interviews, record review, and review of the facility's Covid Response Plan, the facility failed to implement their policies and procedures for 1 of 3 residents (Resident #4) by not placing a mask on a Covid positive resident during a room transfer reviewed for infection control. These failures occurred during a Covid-19 pandemic. Finding included: A facility policy titled Covid Response Plan, last revised June 2020 was reviewed. The policy read in part: All residents to wear masks if they come out of their rooms. Resident #4 admitted to the facility on [DATE]. His [DIAGNOSES REDACTED].#4 quarterly Minimum Data Set ((MDS) dated [DATE] revealed he had moderate cognitive impairments. He required total care with activities of daily living (ADL). Resident #4 had a revised plan of care dated 8/20/2020 related to Covid-19. His interventions were inclusive of supplying the resident with a face mask and encourage to wear if he must leave the room or be transported from the facility. An observation was completed of Resident #4 on 8/20/2020 at 10:01 AM. He was being transported in his wheelchair on the 200 hallway with no mask in place by NA #1. Resident #4 was Covid positive. Continued observation and interview with NA #1 revealed she was instructed to move Resident #4 to room [ROOM NUMBER] by the Administrator. She was not aware if Resident #4 had a mask or not. NA #1 further stated he should probably have on a mask. NA #1 went to retrieve Resident #4 a mask from his room. NA #1 placed the mask on Resident #4. She explained she had received training on infection control practices and Covid-19 inclusive of residents wearing masks while out of their rooms. Review of NA #1's education record revealed she received training on the Covid Response Plan on 7/28/2020 which included residents to wear masks when out of their rooms. A follow up observation of Resident #4 was completed on 8/20/2020 at 10:15 AM from the doorway of his room. The observation revealed Resident #4 continued to have his mask in place. An interview was completed with the Assistant Director of Nursing (ADON), who also served as the Staff Development Coordinator, on 8/20/2020 at 10:35 AM. The ADON explained the process should have been for NA #1 to place an N95 mask on Resident #4 prior to leaving his original room since he was Covid positive. NA #1 should have then transferred him to his new room on the Covid unit. The ADON verbalized staff have been trained and retrained on infection control practices, Covid-19, and ppe (Personal Protective Equipment). An interview was completed with the Administrator on 8/20/2020 at 11:15 AM. He explained everything happened pretty quickly once Resident #4's test results were received on 8/20/2020. The Administrator expressed he informed NA #1 that Resident #4 needed to be transferred to room [ROOM NUMBER] on the Covid unit. He communicated staff had been trained on infection control policies and procedures inclusive of residents wearing masks while out of their rooms. The Administrator verbalized he was not certain why NA #1 did not place a mask on Resident #4 prior to transporting him to his new room. The Administrator voiced all staff were being re-educated on residents wearing masks when leaving their rooms. He further voiced that NA #1 has already received re-education today (8/20/2020) regarding residents having masks in place when leaving their room.