STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	08/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interviews with the Medical Director and staff, the facility failed to implement their abuse policy and procedures by not reporting a resident-to-resident altercation to the State Agency for 1 of 3 residents (Resident #2) reviewed for abuse. Findings included: A review of the facility policy and procedure titled Abuse Investigation and Reporting, with a revised date of March 2017, read in part: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting: 2). Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours. 3). Alleged abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours if the alleged events have resulted in serious bodily injury; or if the events that cause the allegation do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours. Resident #2 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #2 had moderate impairment in cognition, could make self-understood and was usually able to understand others. Further review of the MDS revealed Resident #2 displayed no [MEDICAL CONDITION] or other behaviors during the 7-day MDS assessment period. Review of the nurse notes for Resident #2 revealed the following: An entry dated 07/23/20 at 12:26 PM by Nurse #1 read in part, at 11:50 AM Resident #2 was observed hitting another resident in the face repeatedly until the other resident fell sideways from his wheelchair onto the floor. Staff were unable to physically stop Resident #2 due to his size and violence. Staff tried to deescalate the situation and redirect Resident #2 while he was not attacking the other resident. Staff assisted the other resident to the wheelchair and both residents were separated. Physician notified. Nurse interviewed Resident #2 on what provoked him to start hitting the other resident but his response does not make sense. It seemed that he just attacked other resident without provocation. An second entry dated 07/23/20 at 12:26 PM by Nurse #1 read in part, addendum to note about Resident #2 being violent to another resident without provocation. This nurse was on the phone talking to the doctor and did not hear the conversation of the two residents involved in the altercation. This nurse heard Resident #2 being angry at the other resident and Resident #2 started hitting the other resident, but other witnesses nearby mention they heard the other resident directing cuss words at Resident #2 which provoked him to become violent to the other resident. Review of the facility's abuse investigations completed for the period July 2020 to August 2020 revealed no 24-hour initial or 5-day investigative reports were submitted to the State Agency (SA) related to the resident-to-resident altercation involving Resident #2. An interview was conducted on 08/03/20 at 1:00 PM with Nurse #1. Nurse #1 confirmed he was working on 07/23/20 when Resident #2 was involved in an altercation with another resident. Nurse #1 recalled he was on the phone with a doctor when he heard an argument and as he turned around to look, he noticed Resident #2 talking to a resident in a threatening way and then started hitting the resident in the face. Nurse #1 stated he kept yelling for Resident #2 to stop as staff were unable to physically restrain Resident #2 or keep him from hitting the resident due to his size and aggression at the time. Nurse #1 stated when the other resident fell to the floor, staff were able to distract Resident #2 and assist the other resident to safety. Nurse #1 stated Resident #2's behavior surprised him as he had not witnessed him display this type of aggression toward another resident before. Nurse #1 indicated he notified the Medical Director (MD), Director of Nursing (DON) and filled out an incident report. Nurse #1 added Resident #2 was later sent out to the Emergency Department (ED) for a psychiatric evaluation. A telephone interview was conducted on 08/05/20 at 11:12 AM with Medication Aide (MA) #1. MA #1 confirmed she was working on 07/23/20 when Resident #2 was involved in an altercation with another resident. MA #1 could not recall the exact time but stated when she heard a lot of commotion, she went to see what was going on and saw Resident #2 hitting another resident in the face. MA #1 explained when the other resident was on the floor, she got in-between both residents to keep Resident #2 from hitting him further and staff were able to direct Resident #2 back to his room. She added the other resident was removed from the area, assessed and both residents were separated without further incident. MA #1 indicated she did not witness what led up to the altercation between the two residents but was told the other resident had said something inappropriate to Resident #2. She added she had not witnessed Resident #2 display this type of aggression toward another resident before and felt Resident #2 understood what he was doing but did not think he intentionally meant to harm the other resident. She added Resident #2 was upset and only wanted the other resident to stop whatever he was doing that provoked him. A telephone interview was conducted on 08/05/20 at 12:36 PM with the DON. The DON explained when resident-to-resident incidents occurred, the residents were immediately separated, assessed and monitored. She added the incidents were internally investigated to try and determine the root cause as well as identify any triggers that may have contributed to the behavior exhibited. The DON confirmed she was notified by the Nurse of the resident-to-resident altercation involving Resident #2 on 07/23/20. She stated the residents were separated, both were assessed by the MD and Resident #2 received one-to-one staff supervision until involuntary commitment paperwork was obtained and he was transported to the ED for a psychiatric evaluation that same day. The DON stated she did not report the incident to the SA and explained it was her understanding the facility did not have to report incidents of resident-to-resident abuse if the resident(s) involved had cognitive impairment. A telephone interview was conducted on on 08/05/20 at 3:24 PM with the MD. The MD stated prior to Resident #2's altercation with another resident on 07/23/20, he had seen Resident #2 regularly for behavioral management and the medication adjustments he had made seem to be working well. The MD explained it was difficult to determine the exact contributing factors that led to Resident #2's behaviors but he usually only responded negatively to a situation when provoked. The MD stated he felt Resident #2 understood what he was doing when he reacted aggressively to the situation; however, he lacked impulse control and did not have the capability to understand the consequences his actions caused. A telephone interview was conducted on 08/07/20 at 10:03 AM with the Administrator. The Administrator stated she had only been in her position for a few weeks and did not recall if she was present in the facility at the time the resident-to-resident altercation occurred with Resident #2. The Administrator explained it was her understanding resident-to-resident abuse should be reported to the SA once the facility had evaluated the incident to determine if it met the criteria of abuse such as environmental triggers that could have contributed to the resident's behavior, the resident's level of cognition and whether or not the resident's actions were willful. A joint telephone interview was conducted on 08/07/20 at 10:57 AM with the Administrator and Regional Director of Operations (RDO). The RDO stated he felt Resident #2's actions were an unintentional response to the situation due to his cognitive deficit and poor impulse control related to TBI. The RDO further stated he felt Resident #2's actions did not meet the definition of abuse which was why the incident was not reported to the SA.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observations, staff interviews and review of the facility's policy titled, COVID-19 Policy/Plan for Facilities, the facility failed to ensure nursing staff implemented the facility's infection control measures for wearing surgical masks when 2 of 4 nursing staff (Nurse #2 and Nurse Aide #1) working on a non-isolation, resident hall failed to wear their surgical masks covering both the mouth and nose. This failure occurred during a COVID-19 pandemic. Findings included: A review was completed of a facility policy titled, COVID-19 Policy/Plan for Facilities, revised 05/06/20. The policy specified, in part, all staff will be required to wear a surgical/isolation mask at all times while in the facility. The policy further stated, in part, additional required competencies for all facility staff include proper use of Personal Protective Equipment (PPE). An observation was conducted on 08/03/20 at 10:01 AM of Nurse #2 standing at her medication cart, preparing medications for a resident, with her surgical mask down below her nose. Without adjusting her surgical mask to ensure both her mouth and nose were covered, Nurse #2 entered a resident's room, administered their medications, exited the resident's room, and returned to her medication cart with the surgical mask down below her nose. During an interview on 08/03/20 at 10:05 AM, Nurse #2 confirmed she had received education on the proper use of PPE and was instructed to wear a surgical mask, covering both the mouth and nose, at all times while in the facility. Nurse #2 explained she often pulled the surgical mask down below her nose when standing at her medication cart because her glasses fogged up and she couldn't breathe well with the mask covering her nose. An observation was conducted on 08/03/20 at 10:10 AM of Nurse Aide (NA) #1 providing care to a resident in their room with her surgical mask down below her nose. Without adjusting her surgical mask, NA #1 exited the resident's room, walked down the hall to a resident seated behind the nurses' desk and assisted the resident back to their room with the surgical mask down below her nose. During an interview on 08/03/20 at 10:17 AM, NA #1 confirmed she had received education on the proper use of PPE that included wearing a surgical mask covering both the mouth and nose at all times while in the facility. NA #1 explained when she was busy providing resident care, the surgical mask often slid down and at times, she wasn't even aware that it had fallen down past her nose until it was pointed out to her. During an interview on 08/03/20 at 2:45 PM the Director of Nursing (DON) confirmed she was aware of the concerns identified related to staff not wearing their surgical masks properly. The DON explained she made daily rounds of the facility and provided reminders to staff whenever she noticed them not wearing their surgical mask correctly. She stated she felt staff seemed more mindful of wearing PPE correctly when on the new admission isolation hall but they tended to become more relaxed when in other areas of the facility. The DON added approximately 3 weeks ago, facility staff received re-education on how to properly don (put on) and doff (take off) PPE and were instructed to wear surgical masks covering both the mouth and nose at all times while in the facility. During a telephone interview on 08/04/20 at 3:32 PM, the Administrator stated since starting her employment in July 2020, she had instructed staff on how to properly wear surgical masks covering both the mouth and nose and reinforced they were to be worn at all times while in the facility. The Administrator stated staff were expected to follow facility procedures.