STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

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)
E 0001 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Establish an Emergency Preparedness Program (EP).** Based on record review and staff interview the facility failed to develop and maintain a comprehensive emergency preparedness (EP) program which contained required information to meet the health, safety and security needs of the resident population and staff. This failure had the potential to affect all resident and staff. The findings included: 1. The facility's EP plan was reviewed on 03/11/2020. This review revealed the EP plan did not contain the following required information: a. The EP plan did not contain the subsistence need for staff and population. The plan did not contain the provision of subsistence need for staff and patient whether they evacuate or shelter in place, include but not limited to food, water, medical, and pharmaceutical supplies. Alternate sources of energy to maintain the following: temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarms system, and sewage and waste disposal. b. The EP plan did not contain the roles under a waiver declared by the secretary. The role of the long-term care facility under a waiver declared by the Secretary for the provision of care and treatment at an alternate care site identified by emergency management officials. c. The EP plan did not contain the names and contact information for staff, resident physicians, other long-term care facilities and volunteers. d. The EP plan did not contain emergency officials contact information for the state licensing and certification agency, the office of the state long term care ombudsman and other sources of assistance. e. The EP plan did not have a method for sharing information from the emergency plan that the facility has determine is appropriate with residents and their families or representative. An interview was conducted with the Administrator on 03/11/2020 at 3:47 PM. The Administrator stated that the facility had recently had a mock survey and during that discovered he was missing pieces of the EP plan. The Administrator stated he had made several changes to the EP plan but was obviously still missing some required information. He stated that they trained the staff during orientation and every 6 months thereafter on the EP plan and felt like they were prepared if something occurred but stated he would certainly add the missing components to the EP plan.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and resident and staff interviews the facility failed to place a call light in reach for 1 of 2 residents sampled for falls (Resident #38). The findings included: Resident #85 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #85 had short and long-term memory problems and moderately impaired cognitive skills for daily decision making. In addition, she was usually able to make herself understood, and could usually understand others. The MDS indicated Resident #85 was independent for all activities of daily living (ADL) which included transfers and walking. A review of Resident #85's care plan revealed two care plans for falls. One was dated 08/13/19 and the other on 08/26/19 which read: At risk for falls related unaware of safety needs with history of falls. The interventions included call bell in reach for assistance requests, encourage resident to call for assist, personal items in reach, anticipate and meet the resident's needs, increase observation, a sign in the room to call for assistance, and a psychiatric referral/medication review. During an observation on 03/08/20 at 12:23 PM revealed resident #85 was lying on the edge of her bed facing the window. Her call light was draped across a wire rack and attached to the wall which was approximately 4-5 feet off the floor next to the privacy curtain and not within Resident #85's reach. An additional observation on 03/09/20 at 10:44 AM revealed Resident #85's call light was again draped across the wire rack on the wall when Medication Aide (MA) #1 brought her medications in the room. Resident #85 was complaining of her head and low back hurting from a recent fall she had. MA #1 administered the medications and left the room to make the nurse aware without placing the call light within reach. An observation on 03/10/20 at 2:44 PM revealed Resident #85 standing by the window in her room. Resident #85's call light was clipped to her blanket and her telephone was lying next to her pillow on the bed. When they surveyor asked Resident #85 about what the items were, Resident #85 pointed to the phone and call light and responded that the staff had given her those today so she could call if she needed any help so she does not get hurt again. An interview with Nurse #1 on 03/10/20 at 9:03 AM revealed she was the nurse assigned to provide care for Resident #85 and reported Resident #85 could make her needs known but had occasional periods of confusion. Nurse #1 reported Resident #85 should have her call light within reach, due to both a history of falls and a recent fall with injury. An interview with MA #2 on 3/10/20 at 3:47 PM revealed MA #2 usually provided showers but was assigned to provide care for Resident #85 on 3/10/20 on day shift. MA #2 stated Resident #85 was able to make her needs known, but MA #2 stated she stated she had never given Resident #85 a call light because she wouldn't use it. An interview with Nurse Aide (NA) #4 on 3/10/20 at 3:53 PM revealed she was assigned to provide care for Resident #85 on 03/10/20. NA #4 stated Resident #85 was alert with some confusion but able to make her needs known to staff. NA #4 stated she did not give Resident #85 a call light because she didn't think she could use it. An interview with NA# 5 on 3/11/20 at 9:05 AM revealed she was familiar with Resident #85 and was aware Resident #85 had a call light to be used to call for assistance although did not recall if Resident #85 had used it in the past. NA# 5 acknowledged Resident #85 had a history of [REDACTED].#85. An interview with MDS Coordinator #2 on 03/10/20 at 5:27 PM revealed Resident #85 had a care plan for falls to include provide Resident #85 a call light within reach. MDS Coordinator #2 stated Resident #85 was to have a call light in reach to assist in prevention of falls and felt that the intervention was appropriate because she could make her needs known. An interview with the Director of Nursing (DON) on 03/11/20 at 9:11 AM revealed Resident #85 to be alert and oriented with periods of confusion. The DON stated Resident #85 was highly functional and particular about her routine. She stated she was aware Resident #85 had a call light for assistance, although she could not recall if Resident #85 had used it before. The DON further revealed Resident #85 had periods of confusion and the call light was in place to assist in the prevention of falls.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete the comprehensive Minimum Data Set assessment within 14 days of admission for 1 of 4 residents reviewed with pressure ulcers (Resident #78). The findings included: Resident #78 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the comprehensive Minimum Data Set ((MDS) dated [DATE] indicated that Resident #78 had long- and short-term memory loss and was moderately impaired for daily decision making. The MDS further revealed that the Resident #78 required extensive assistance with activities of daily living and had no pressure ulcers. The MDS indicated it was completed on 03/02/2020 by MDS Coordinator #1. An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. MDS Coordinator #2 stated that she had worked at

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

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F 0636 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the facility for 6 months and had completed her training that was provided by MDS Coordinator #1. MDS Coordinator #2 stated that they had 14 days from the assessment reference date (ARD) to complete the MDS assessment and indicated that was for all types of assessments. She added except entry assessments and those needed to be completed within 6 days. A follow up interview was conducted with MDS Coordinator #2 on 03/11/2020 at 9:42 AM. MDS Coordinator #2 confirmed that admission MDS assessments had to be completed within 14 days of admission to the facility. She stated that MDS Coordinator #1 was out of work and unavailable for interview but indicated the MDS assessment for Resident #78 should have been completed no later than 0[DATE]20. MDS Coordinator #2 confirmed that the MDS assessment was completed on 03/02/2020. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that both MDS coordinators were new to their positions and were still very much learning all the responsibilities that came with the position. The DON stated she had no idea why the MDS assessment for Resident #78 was not completed within 14 days of admission but stated she would expect that it would be completed timely by 0[DATE]20. She added that MDS Coordinator #1 was out of work and unavailable for interview.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to complete a baseline care plan within 48 hours of admission for 2 of 4 residents (Resident #78 and Resident #237) reviewed for pressure ulcers. The findings included: 1. Resident #78 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a facility document dated 02/11/2020 and titled Baseline Care Plan revealed that part of the assessment was complete and part of it was not. The following sections were blank: communication care planning, vision care planning, hearing care planning, fall care planning, cognitive impairment care planning, urinary incontinence care planning, bowel incontinence care planning and base line care plan summary along with the signature section. The baseline care plan contained no staff signature for completion and the section the resident or family had been provided a copy of the baseline care plan was blank. Review the Minimum Data Set ((MDS) dated [DATE] revealed that Resident #78 had long/short term memory problem and was moderately impaired for daily decision making. The MDS further revealed that Resident #78 required extensive assistance with activities of daily living. An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. MDS Coordinator #2 stated baseline care plans were completed as a team during the morning meeting when all disciplines were gathered together and have input to the care plan. The form was located in the electronic medical record and it was printed off and signed by the resident or the family and then uploaded to the electronic record. The MDS Coordinator #2 stated that she could not explain why the base line care plan for Resident #78 was not completed and why it did not contain signature for completion or the resident/family signature. A follow up interview was conducted with MDS Coordinator #2 on 03/11/2020 at 9:42 AM. She confirmed that Resident #78 baseline care plan was not completed and was not scanned into the system after obtaining family or resident signature. She stated that base line care plan should have been completed within 48 hours of admission and once signed by the family/resident uploaded into his electronic medical record. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that baseline care plans were completed as a team during the morning clinical meeting. She stated that after they reviewed the hospital record and admission assessment, they develop the baseline care plan. Once the plan had been developed the plan was discussed with the resident and/or family and signed and then scanned into the resident medical record. The DON stated that she was aware that there were issues with the care planning process and that she was working closely with the MDS Coordinators to get the process up to speed. The DON stated she expected the baseline care plan to be developed, completed, and scanned into the resident's medical record within 48 hours of admission to the facility. 2. Resident #237 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a facility document dated 03/02/2020 and titled Baseline Care Plan revealed that part of the assessment was complete and part of it was not. The following sections were blank: mood and psychosocial wellbeing, special instructions, baseline care plan summary and signature lines for completion. The baseline care plan contained no staff signature for completion and the section the resident or family had been provided a copy of the baseline care plan was blank. No Minimum Data Set (MDS) information was available for Resident #237. An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. MDS Coordinator #2 stated baseline care plans were completed as a team during the morning meeting when all disciplines were gathered together and have input to the care plan. The form was located in the electronic medical record and it was printed off and signed by the resident or the family and then uploaded to the electronic record. The MDS Coordinator #2 stated that she could not explain why the base line care plan for Resident #237 was not completed and why it did not contain signature for completion or the resident/family signature. A follow up interview was conducted with MDS Coordinator #2 on 03/11/2020 at 9:42 AM. She confirmed that Resident #237 baseline care plan was not completed and was not scanned into the system after obtaining family or resident signature. She stated that base line care plan should have been completed within 48 hours of admission and once signed by the family/resident uploaded into his electronic medical record. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that baseline care plans were completed as a team during the morning clinical meeting. She stated that after they reviewed the hospital record and admission assessment, they develop the baseline care plan. Once the plan had been developed the plan was discussed with the resident and/or family and signed and then scanned into the resident medical record. The DON stated that she was aware that there were issues with the care planning process and that she was working closely with the MDS Coordinators to get the process up to speed. The DON stated she expected the baseline care plan to be developed, completed, and scanned into the resident's medical record within 48 hours of admission to the facility.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to develop a comprehensive care plan for pressure ulcers as directed by the care area assessment for 1 of 4 residents reviewed with pressure ulcers (Resident #78). The facility also failed to implement fall interventions for 1 of 2 resident reviewed for supervision to prevent accidents (Resident #85). The findings included: 1. Resident #78 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review the Minimum Data Set ((MDS) dated [DATE] revealed that Resident #78 had long/short term memory problem and was moderately impaired for daily decision making. The MDS further revealed that Resident #78 required extensive assistance with activities of daily living and had no pressure ulcers during the assessment reference period. Review of the Care Area Assessment (CAA) dated 0[DATE]20 read in part, Resident #78 triggered for pressure ulcers due to him needing extensive assistance with bed mobility and was always incontinent of bowel and bladder. Resident #78 has right lower leg contracture of muscle and left lower leg contracture of muscle and required assistance with personal care. The CAA indicated that they would proceed to the care plan. The CAA assessment was completed by MDS Coordinator #1. Review of Resident #78's care plan revealed no care plan for pressure ulcers or the prevention of pressure ulcers. An interview was conducted with MDS Coordinator #2 on 03/10/2020 at 4:38 PM. She explained that MDS Coordinator #1 who completed Resident #78's MDS dated [DATE] and CAA dated 0[DATE]20 was out of work and unavailable for interview. She stated that once the MDS was completed the comprehensive care plan was developed by reviewing the baseline care plan and the triggers off the CAA section of the MDS. MDS Coordinator #2 stated that if the care plan decision for the CAA was yes then the care plan would be developed and if the decision was no the care plan would not be developed. She stated that it was possible just an oversight that MDS Coordinator #1 did not initiated the care plan as she elected to on the CAA. She added that she would expect a care plan to have been developed as directed by CAA. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 9:59 AM. The DON stated that the both MDS Coordinator #1 and #2 were fairly new and still very much learning their responsibilities in the facility. The DON stated she was certain the lack of care plan as directed by the CAA was an oversight by MDS Coordinator #1. She further stated that if the CAA was written and the care plan decision was yes then she would expect to see a care plan initiated but confirmed Resident #78 did not have a care plan for pressure ulcers or the prevention of pressure ulcers.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 2. Resident #85 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #85 had short and long-term memory problems and moderately impaired cognitive skills for daily decision making. In addition, she was usually able to make herself understood, and could usually understand others. The MDS indicated Resident #85 was independent for all activities of daily living (ADL) which included transfers and walking A review of Resident #85's care plan revealed two care plans for falls. One was dated 08/13/19 and the other on 08/26/19 which read: At risk for falls related unaware of safety needs with history of falls. The interventions included call bell in reach for assistance requests, encourage resident to call for assist, personal items in reach, anticipate and meet the resident's needs, increase observation, a sign in the room to call for assistance, and a psychiatric referral/medication review. An observation of Resident #85 on 03/08/20 at 12:23 PM revealed resident was lying on the edge of her bed facing the window. Her call light was draped across a wire rack and attached to the wall which was approximately 4-5 feet off the floor next to the privacy curtain and not within Resident #85's reach. An additional observation of Resident #85 on 03/09/20 at 10:44 AM revealed the call light was again draped across the wire rack on the wall when Medication Aide (MA) #1 brought her medications in the room. Resident #85 was complaining of her head and low back hurting from a recent fall she had. MA #1 administered the medications and left the room to make the nurse aware without placing the call light within reach. An observation on 03/10/20 at 2:44 PM revealed Resident #85 standing by the window in her room. Resident #85's call light was clipped to her blanket and her telephone was lying next to her pillow on the bed. When they surveyor asked Resident #85 about what the items were, Resident #85 pointed to the phone and call light and responded that the staff had given her those today so she could call if she needed any help so she does not get hurt again. An interview with MA #2 on 3/10/20 at 3:47 PM revealed MA #2 usually provided showers but was assigned to provide care for Resident #85 on 3/10/20 on day shift. MA #2 stated Resident #85 was able to make her needs known, but MA #2 stated she stated she had never given Resident #85 a call light because she wouldn't use it. An interview with Nurse Aide (NA) #4 on 3/10/20 at 3:53 PM revealed she was assigned to provide care for Resident #85 on 03/10/20. NA #4 stated Resident #85 was alert with some confusion but able to make her needs known to staff. NA #4 stated she did not give Resident #85 a call light because she didn't think she could use it. An interview with NA# 5 on 3/11/20 at 9:05 AM revealed she was familiar with Resident #85 and had been assigned to provide her showers in the past. NA#5 stated was aware Resident #85 had a call light to be used to call for assistance although did not recall if Resident #85 had used it in the past. NA# 5 acknowledged Resident #85 had a history of [REDACTED].#85. An interview with Nurse #1 on 03/10/20 at 9:03 AM revealed she was the nurse assigned to provide care for Resident #85 and reported Resident #85 could make her needs known but had occasional periods of confusion. Nurse #1 reported Resident #85 should have her call light within reach, due to both a history of falls and a recent fall with injury. An interview with MDS Coordinator #2 on 03/10/20 at 5:27 PM revealed Resident #85 had a care plan for falls. MDS Coordinator #2 provided a paper copy of Resident #85's plan of care and acknowledged Resident #85's fall care plan included an intervention for her call light to be in reach. MDS Coordinator #2 was unable to verify which MDS Coordinator added the intervention; however, felt that the intervention was appropriate because Resident #85 could make her needs known. An interview with the Director of Nursing (DON) on 03/11/20 at 9:11 AM revealed Resident #85 to be alert and oriented with periods of confusion. The DON stated Resident #85 was highly functional and particular about her routine. The DON indicated she expected care plans to be followed by all staff as they are written. She stated she was aware Resident #85 had a call light for assistance although, she could not recall if Resident #85 had used it before. The DON further revealed Resident #85 has periods of confusion and the call light was in place to assist in the prevention of falls.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to keep a urinary catheter drainage bag off the floor for 1 of 1 sampled resident reviewed for urinary catheters (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A review of an admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for toileting and he had an indwelling urinary catheter. An observation on 03/08/20 at 11:47 AM revealed Resident #1 was sitting in a wheelchair next to his bed. A urinary catheter bag was hooked under Resident #1's wheelchair and the urinary catheter drainage bag was lying on the floor under the wheelchair. An observation on 03/08/20 at 12:03 PM revealed Resident #1 was lying in bed and his bed was in the lowest position to the floor. A urinary catheter drainage bag was hooked to the bottom frame of the bed and the urinary catheter bag was touching the floor. An observation on 03/08/20 at 3:17 PM revealed Resident #1 was lying in bed with his bed in low position to the floor. A urinary catheter drainage bag was hooked to the bottom frame of the bed and the bottom of the catheter bag was on the floor. An interview on 03/11/20 at 10:02 AM with Nurse Aide #1 revealed she was assigned to care for Resident #1. She stated urinary catheter bags were supposed to be hooked under the resident's wheelchair so they would not drag on the floor. She explained when residents were in bed, she fastened the catheter bag to the bed frame, and they were not supposed to touch the floor. She further explained sometimes when staff got Resident #1 out of bed, they did not hook the catheter securely and it slipped down to the floor. She confirmed she was assigned to care for Resident #1 on 03/08/20 and she recalled she saw Resident #1's catheter bag once on 03/08/20 and she moved it, so it wasn't touching the floor. An interview on 03/11/20 at 11:18 AM with Nurse #1 revealed she was assigned to the hall on 03/08/20 where Resident #1 lived. She stated urinary catheter bags were supposed to be kept off the floor. She explained catheter bags should be hooked under the wheelchair to the frame or on the bed frame when residents were in bed so that the catheter bag did not touch the floor. She stated she remembered getting Resident #1 up out of bed on 03/08/20, but she did not recall looking at his catheter bag. An interview on 03/11/20 at 2:52 PM with the Director of Nursing revealed urinary catheter bags should be kept below the level of the bladder. She stated catheter bags should not be on the floor. She explained most residents were in low beds for fall precautions and it was a challenge to keep the catheter bag off the floor. She confirmed it was the facility policy that the catheter tubing and drainage bag were kept off the floor.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, staff interviews, and Nurse Practitioner interview the facility failed to obtain a physician's order for oxygen therapy for 1 of 4 sampled residents reviewed for respiratory care. The findings included: Resident #61 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Physician's orders for Resident #61 dated 12/13/19, revealed no physician order for [REDACTED]. An observation of Resident #61 on 03/08/20 at 3:34 PM revealed the resident's oxygen cannula was not in her nose and the oxygen tubing was attached to an oxygen concentrator. The concentrator was set at 4 liters per minute. An observation of Resident #61 on 03/09/20 at 8:27 AM revealed she was in bed with a nasal cannula in her right nostril. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 liters per minute. An observation of Resident #61 on 03/09/20 at 2:49 PM revealed the oxygen cannula was in place in both nostrils and the oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 liters per minute. An observation of Resident #61 on 03/10/20 at 9:32 AM revealed the oxygen cannula was not in the resident's nostrils and was hanging down the left side of Resident #61's chest. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 liters per minute. An observation of Resident #61 on 03/10/20 at 3:04 PM revealed the oxygen tubing wrapped around the resident's left ear, the oxygen cannula was not in the resident's nostrils. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 liters per minute. A review of Resident #61's oxygen saturations on 03/10/20 at 5:35 PM revealed the resident's oxygen saturations were 94 to 98 percent on room air and 92 to 99 percent when on oxygen. An observation of Resident #61 on 03/11/20 at 8:21 AM revealed the oxygen cannula was in place in both of the resident's nostrils. The oxygen tubing was attached to an oxygen concentrator. The concentrator was on and set at 4 liters per minute. An interview with Nursing Assistant (NA) #3 on 03/11/20 at 9:17 AM revealed the resident was supposed to have oxygen on but the resident was constantly taking it off. The NA further stated every time any of the staff saw it off, they would go in and put it on. An interview with NA #2 on 03/11/20 at 9:28 AM revealed Resident #61 was supposed to wear oxygen, but she wouldn't leave it on. She further revealed the resident would take it off and put it under her pillow or hang it around her ear. The NA

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) stated we've tried to keep the oxygen on her but at times she would take it off. An interview with Nurse #1 on 03/11/20 at 10:11 AM revealed if a resident was on oxygen, they would need an order as it was considered a medication. Nurse #1 reviewed the orders for Resident #61 and stated she did not see an order for [REDACTED].#61's chart and stated she did not see an order and the resident had used it enough to have an order. She further stated she would get the order now and once the order was received it would be care planned. An interview with the Nurse Practitioner on 03/11/20 at 3:15 PM revealed she would not expect any untoward effects from Resident #61 receiving oxygen without an order due to the resident having a [DIAGNOSES REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, record review and staff interview the facility failed to discard expired medications from 1 of 2 (central supply) medication storage areas observed. This allowed those medication to be availabe for use. The findings included: An observation of the central supply closet was made on 03/10/2020 at 4:11 PM with the Central Supply Clerk. The observation revealed the following: - 1 unopened bottle of Fiber therapy 16 ounce that expired 01/20. - 2 unopened bottle of Arthritis pain relief 650 milligram (mg) that expired 12/19. - 1 unopened bottle of Oyster shell calcium 500 mg that expired 01/20. - 1 opened bottle of Mucus Relief DM that expired 02/20. - 1 unopened bottle of Vitamin B-2 that expired 12/19. An interview was conducted with the Central Supply Clerk on 03/10/2020 at 4:14 PM. The Central Supply Clerk stated that she went through the central supply closet every week after which she would order needed medications and then when they arrived at the facility, she would put them up. She added that she would stock not only the central supply closet, but she would also take needed items to the medication rooms and medication carts as needed. The Central Supply Clerk stated that she just overlooked the expired medication because there was so many bottles of medication in the central supply closet. An interview was conducted with the Director of Nursing (DON) on 03/11/2020 at 10:12 AM. The DON stated that the Central Supply Clerk stocked the medication in the central supply closet and the staff would get what they needed. The DON further stated that the staff were expected to check each bottle before they were opened, and she was confident that the expired medication would not have made it to the medication carts for administration to the residents. She added that she spoke to the Central Supply Clerk to find out why the expired medications were in the central supply closet and was told just how many bottles of medication were in there. The DON stated first thing they were going to do was compile a list of frequently used medication and get rid of the other stuff to cut down on the volume of medications in the central supply closet. However, the DON stated she would expect the expired medication to have been discarded and not available for use in the central supply closet.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview, the facility failed to serve food and coffee at lunch and supper meals that were palatable and at an appetizing temperature for 1 of 2 resident meals sampled for palatability (Resident #8). The findings included: Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An undated nutritional care plan reveals Resident #8 to have interventions that included empowering Resident #8 to make food choices and staff were to offer and provide food substitutes. A quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #8 to be able cognitively intact, able to make her needs known, and require setup assistance with her tray for eating. An observation on 03/08/20 at 12:34 PM of Resident #8 sitting on the side of the bed with her lunch tray on the bedside table in front of her. The tray contained a slice of pork tenderloin and 2 thin slices of tomatoes. She was attempting to use a butter knife to cut the pork but was unsuccessful and began trying to bite and tear the pork with her fingers. During an interview on 03/08/20 at 12:34 PM, Resident #8 stated she the pork was to tough for her to cut and she had to bite it and tear it apart with her hands. She revealed she felt the tomato slices were thin, soggy and had previously requested the kitchen staff deliver tomatoes in a separate dish because the warm plate made them lose their firmness. She felt she had been fussed at when she voiced her concerns and felt there was no longer any point in asking because the kitchen did not listen to her. An observation and interview with Resident #8 on 03/09/20 at 5:09 PM revealed she opened the lid of the supper tray that contained a hot dog and a pack of chips. A cup of coffee was placed to the edge of the plate without a lid and no visible steam present. Resident #8 picked up the cup of coffee and indicated it was cold. The hotdog had been cut in half and she ate a couple of bites from one portion of the hotdog and then pointed the uneaten half hotdog in the direction of the surveyor and said feel and taste this, it's terrible. I can't eat this. The inner portion of the hot dog wiener contained pink meat with a darker red circular area in the center. The hotdog wiener was not warm, and the bun was also cold, very dry and firm to the touch. She stated she had made many requests known to kitchen staff but had been told she needed to quit wasting food when she voiced her concerns. An interview with the Social Worker (SW) on 03/10/20 at 09:36 AM revealed she was aware that Resident #8 had many concerns in the past that included food not being at the correct temperature and not wanting the Dietary Manager (DM) in her room. The SW states Resident #8 had attended and previously voiced these complaints during a resident council meeting. During an interview with the DM and Regional Dietary Consultant (RDC) conducted on 3/10/20 at 10:00 AM, the DM and RDC were made aware of the observations of Resident #8's meals on 03/08/20 and 03/09/20. The DM voiced she was unaware of any concerns with the pork tenderloin served on 03/08/20. The DM revealed the hotdog wieners were delivered pre-cooked and were boiled by the cooks before they were served. She further acknowledged the hotdog buns used to serve the supper meal on 03/09/20 were stamped with a label of 12/20/19 which she was unable to verify the date the hot dog buns were pulled from the freezer to be thawed. The DM stated she was unsure why the hotdog bun would have been hard, the bun and wiener cold, or the coffee served cold to Resident #8. She acknowledged Resident #8 had voiced food concerns in the past but did not recall what they were during the interview.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to properly label, date, and seal stored food items and failed to discard stored foods after the manufacturer's expiration date in 1 of 1 dry storage areas, 1 of 1 walk-in freezers, and 1 of 1 walk in refrigerators. The facility further failed to store pots, knives, and adaptive plates under sanitary conditions in the kitchen. These practices had the potential to affect all residents who receive oral food nutrition. The findings included: A brief tour of the kitchen was conducted on [DATE] at 10:41 AM with Cook #1. The tour of the dry storage room revealed items as followed: three 1-gallon plastic bags containing an unidentified dry substance. Each of the bags were labeled with an open date written with a black marker, but no item identification or discard date could be located. An unsealed 1- gallon plastic bag containing three opened bottles of liquid ice cream toping (fudge, caramel, and cherry) was located on a dry shelf and did not contain an open or discard date on the bag. Three 48 oz jars of Dijon mustard with the date ,[DATE] written in black marker on the lid and an expiration date on the back of the jar of 14 [DATE]. An undated twenty-five-pound box of Par Boiled Long Grain Rice contained a blue liner bag that was unsealed. A 1- gallon plastic bag containing an unidentified yellow colored noodle was labeled with the dates of ,[DATE] and ,[DATE]. A 160 oz package containing a half a bag of multi-color pasta was labeled with a date of ,[DATE] and no expiration or discard date could be located on the package. A bread rack containing two 12-count bags of golden hamburger buns with a best by (NAME)03, two 12-count bags of golden hotdog buns with a best by date of (NAME)04, five loaves of whole grain white bread with a best by date of (NAME)04, and seven 16-count hotdog buns with a stamped label date of [DATE]. During the tour, all expired, and post discard dated food items were removed from the dry storage room in the kitchen by Cook #1. During a continuous tour of the kitchen on [DATE] at 10:40 AM, the walk-in freezer revealed an open and unlabeled bag containing seven pieces of an unidentified light brown meat and another half bag of a diced meat. It also revealed a 1-gallon plastic bag containing two pie crust with no labels on the package. The kitchen tour continued on [DATE] at 10:40 AM with the Dietary Manager (DM) and further revealed the walk-in refrigerator contained a large plastic container of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) peaches. The container of peaches was labeled with a discard date of [DATE]. A cardboard box of hotdogs was located on the bottom shelf in the refrigerator and was unsealed and unlabeled with an open or discard date. An interview with Cook #1 was conducted on [DATE] at 10:41 AM. Cook #1 revealed all items should be labeled with an open and discard date and should include an item identification. She stated items should be checked and discarded at the end of the use by or expiration dates from the manufacturers. She identified the substances in the three 1-gallon plastic bags to be cereal: Rice Krispy, Cornflakes, and Cheerios. Cook #1 further revealed the blue bag inside the box that contained rice should have been resealed after each use. She acknowledged the stamped date of [DATE] and stated she had not ever looked at the best by dates on the bread because the facility received a bread delivery every week and she thought the delivery worker removed the old bread at that time. Cook #1 indicated she believed the hot dog buns were delivered by the bread delivery person and she was unsure why the hot dog buns stamped [DATE] would be on the shelf and not discarded by the bread delivery worker each week. Cook #1 identified the 7 pieces of unidentified meat to be country fried steak and the diced meat to be chicken. She stated both food items were to have been labeled to identify the food identification, open and discard dates. Cook #1 said the bag containing the pie crusts should have been labeled with an open and discard date. During an interview with the DM conducted on [DATE] at 11:31 AM, the DM revealed items were to be labeled with the item identification, dated opened, and a discard date and staff had been educated on proper food storage policies. She indicated all food items were to be discarded according to the discard label placed when the item is opened or the manufacturers expiration dates and not made readily available for use in the dry storage room after that date. The DM stated most of the facility bread deliveries were brought to the facility fresh; however, she believed the hot dog buns with the stamped label of [DATE] were delivered frozen through their standard food delivery company. She further stated the frozen hot dog buns would have been thawed by staff prior to use but was unable to verify the date the hotdog buns were removed from the freezer for thawing to ensure the staff discarded any unused portion on the appropriate date because they had not been labeled when removed from the freezer. During the interview, she said she was unsure of the shelf life of the buns in the freezer or after thawed. She verified the original box the hotdog buns were shipped in had been discarded. The DM confirmed the items were unlabeled and stated items stored in the walk-in freezer and refrigerator were to be labeled with a food identification, open date, and a discard date. A follow-up tour of the kitchen was conducted on [DATE] at 10:00 AM with the DM and the Regional Dietary Consultant (RDC). The tour revealed there were four 16-count packages of hotdog buns containing a stamp label of [DATE] and four loaves of white bread dated with a best by date of [DATE] readily available for use on the bread rack in the dry storage room. The tour further revealed an overhead rack above the food preparation area with a quarter inch thick layer of a dust attached to hooks where the large cooking pots were being hung for storage. During an interview with the DM and RDC conducted on [DATE] at 10:00 AM, the DM and RDC acknowledged the hotdog buns with the stamped date of [DATE] and the bread with the best by [DATE] label on the bread racks in the dry storage room and removed them from circulation. The DM confirmed the facility served hot dogs during lunch and supper as an alternative every day. The RDC revealed she tried contacting the bread delivery service and the standard food service delivery company for clarification about the bread stamp labels and was awaiting a follow-up. The DM confirmed the overhead rack containing the large cooking pots contained a thick layer of dust. She stated she provided staff with a list of areas that are to be deep cleaned weekly and expected all areas in the kitchen to be kept clean and sanitary. The DM and RDC verified the visible dust had been there longer than a week. During an interview with Cook #2 conducted on [DATE] at 4:00 PM, Cook #2 revealed the cook assigned to work on 2nd shift was responsible for panning bread each day and were to place it on the designated racks in the dry storage room to thaw. She stated the pans are labeled when the items are panned. These labels contain the item identification, the pan date, and the discard date which is 2 days after the pan date. Cook #2 stated the buns and slice bread are always kept in the dry storage room on racks and she has never known either to be in the freezer. She further indicated the only bread items that are kept frozen for panning were rolls and biscuits. Cook #2 said the facility receives a bread delivery each week on Thursdays and it was not in the frozen form. She indicated she had never looked at the best by date on any bread label while working as a cook in the facility. During an interview with Cook #3 conducted on [DATE] at 4:15 PM, Cook #3 revealed she had worked as a cook on [DATE] during lunch and supper and prepared hot dogs as an alternative to the menu item. Cook #3/Dietary Aide further indicated she served the hotdogs on the buns she retrieved from the bread racks in the dry storage room. She stated she did not look at the package for a use by, an expiration or discard date to determine if the hotdog buns should be served to the residents. Cook #3/Dietary Aide said she did not ever recall thawing hotdog buns from the freezer because the buns were always located on the bread racks in the dry storage area. An additional follow-up tour was conducted in the kitchen during the meal delivery service assembly line on [DATE] beginning at 11:40 AM. A quarter inch thick layer of dust was observed to be covering the surface of the knife storage block to the left of the hand washing sink in the food preparation area and on two layers of shelves on the meal tray line where adaptive plates were located. During an interview with the DM and RDC conducted on [DATE] at 1:00 PM, both the DM and the RDC acknowledged the thick layer of dust covering the surface of the knife storage block and the shelved on the meal tray line and these should have been cleaned during the weekly deep cleaning.