STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. Building B. Wing	06/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Monroe	204 Old Highway 74 East Monroe, NC 28112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32503 Based on observations, resident interviews, staff interviews and record review the facility failed to 1) respond to the call bell when toileting assistance was required resulting in a resident who was occasionally incontinent becoming soiled causing the resident to feel frustrated and upset; 2) respond to a resident's need to go to bed and alleviate pain by not answering the call light for 40 minutes; and 3) stood up over a resident at the bedside while providing eating assistance for 3 of 3 residents (Residents #14, #6, & #16) reviewed for dignity. The findings included: 1. Resident #14 was admitted to the facility on [DATE]. Her diagnoses included Diabetes, muscle weakness and amyotrophic lateral sclerosis (ALS). The quarterly Minimum Data Set assessment dated [DATE] reported Resident #14 was cognitively intact. She required extensive assistance for toileting and transfers. Resident #14 required staff assistance for moving on and off the toilet. She was occasionally incontinent of bowel and bladder. The care plan revised on 1/3/22 indicated Resident #14 had an alteration in musculoskeletal status related to ALS. The interventions included Anticipate and meet needs. Be sure call light is within reach and respond promptly to all request for assistance. The care plan also indicated Resident #14 had an ADL (Activities of Daily Living) self-care performance deficit related to her disease process of ALS. The intervention included Toilet Use: The resident requires extensive assistance by staff for toileting. On 6/13/22 at 4:02 PM Resident #14 stated she had to wait over an hour to go to the bathroom. She said she used her call bell to ask for assistance, but no one came to provide her assistance to the bathroom. She said she did not remember the exact date but had it in a text message on her telephone. She explained the time of the text messages verified the length of time she had to wait before anyone came to assist her to the bathroom. On 6/14/22 at 5:26 PM a review of the text messages on Resident #14's telephone revealed on 4/3/22 no one responded to her call bell for over an hour and a half (messages at 8:59 am and 10:37 am), and she had a bowel movement on herself due to no one responding to her call bell. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 6/14/22 at 5:26 PM during an interview Resident #14 stated having a bowel movement on herself made her feel upset. She stated she was frustrated and more concerned about the damage it could cause to have stool in and around her peritoneal area which could cause some infection or lead to an ulcer. A review of the Nursing Assignment for 4/3/22 revealed only Nursing Assistant (NA) #4 and NA #5 worked on the 7:00 AM -3:00 PM shift. Attempts to interview NA #4 and NA #5 were unsuccessful. On 6/17/22 at 10:10 AM Scheduler #1 stated she was a nursing assistant and on 4/3/22 worked the 3:00 PM - 11:00 PM shift. She stated she was not aware of Resident #14 having soiled herself that day. On 6/16/22 at 3:45 PM the Assistant Director of Nursing reported she was unaware Resident #14 had soiled herself due to her call bell not being answered. 37468 2. Resident #6 was admitted to the facility on [DATE]. The resident's active diagnoses included stroke, anemia, coronary artery disease, spinal stenosis of lumbar region with neurogenic claudication, and lower back pain. Resident #6's Minimum Data Set assessment dated [DATE] revealed she was assessed as cognitively intact and had no behaviors. She required extensive assistance with bed mobility and transfers. Resident #6's care plan dated 3/31/22 revealed she was care planned to have an activities of daily living self-care performance deficit related to activity intolerance, confusion, and impaired balance. The interventions included the resident required extensive assistance by staff for transfers. During a continuous observation on 6/13/22 from 2:45 PM - 3:28 PM, Resident #6's call light was observed on. Resident #6 was observed up in her wheelchair in her room watching TV. The resident stated to the surveyor that her legs would get tired and start hurting around 3:00 PM when she was up in her wheelchair. She stated it was okay if the surveyor observed how long it would take for staff to answer her call bell. She stated it would probably be a while because she would request to go to bed and sometimes it took 'hours.' She stated she told the nurse about five minutes ago that she was in pain and needed to be put to bed which always alleviated the pain to her legs from being in the chair all day. Resident #6 stated the nurse gave her some pain medication and then informed her she would get the nurse aide. She stated she had considered going on the hall to find someone but she self-propelled with her feet and she believed it would cause her more pain to find someone than to wait for an hour. The resident stated her pain was at a 5 out of 10 which she considered bearable but being left in the chair made her feel uncomfortable. Resident #6 concluded she would let the surveyor know if the pain became unbearable and needed the surveyor to find staff for her but would rather the surveyor see how long it took for the call light to be answered. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	The continuous observation continued and on 6/13/22 at 3:24 PM Nurse Aide #2 entered the resident's room and asked what Resident #6 needed. Resident #6 informed the nurse aide she needed to go to bed. The nurse aide went to find another staff to assist, and Resident #6 was put in bed at 3:28 PM. Nurse Aide #2 stated she was not Resident #6's nurse aide but she had noted the call light was on, so she was helping. She did not know where the resident's nurse aide or nurse was. During an interview on 6/13/22 at 4:07 PM Nurse Aide #1 stated she was Resident #6's nurse aide. She further stated she was unaware of Resident #6's call light being on because she had a split assignment and was on another hall, she then checked the halls before going to break at 3:00 PM. She stated she did not know how she missed her light was on at 2:45 PM as she had checked the hallways prior to break. She stated breaks lasted 30 minutes, so the issue was resolved before she returned to the hall. She concluded from 2:45 PM to 3:24 PM was too long for a call light to be on and it should have been answered immediately or within five minutes depending on if she was with another resident. During an interview on 6/13/22 at 4:09 PM Nurse #1 stated she was Resident #6's nurse. She further stated call lights were to be answered as soon as they were noted to be on. She stated a call light being unanswered from 2:45 PM to 3:24 PM was too long for a call light to remain unanswered. She stated she went to break at 3:00 PM and it was a thirty-minute break which was why she had not identified Resident #6 had her light on. During an interview 6/13/22 at 4:16 PM the Director of Nursing stated 40 minutes was not an acceptable amount of time for a resident to wait on a call light and that staff responsible for the same residents should coordinate their breaks to be staggered in order to have someone monitoring the hall during the other staff member's break. 40200 3. Resident #16 was admitted to the facility on [DATE] with diagnoses which included non-Alzheimer's dementia and dysphagia (difficulty swallowing foods or liquids). The quarterly Minimum Data Set indicated Resident #16 had severe cognitive impairment and was totally dependent on staff for eating. On 6/13/22 at 12:45 PM an observation was made of Nurse Aide (NA) #2 standing at Resident #16's bedside while feeding the resident her lunch. The resident's head of bed was in an upright position and the NA stood above the resident's eye level during the dining experience. There was no chair in the room for the NA to use. On 6/13/22 at 12:54 PM an interview was conducted with NA #2 who stated she had never been trained to sit while feeding a resident. On 6/13/22 at 12:59 PM an interview was conducted with the Director of Nursing (DON) stated that staff should know to sit while feeding a resident and she did not know why the NA had not done so. On 6/15/22 at 3:31 PM an interview was conducted with the Administrator who stated that staff should not stand to feed a resident and he did not know why this had occurred.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on observations, record review, and resident, staff, and Physician interviews, the facility failed to obtain orders and provide treatment of a right heel vascular ulcer (Resident #53) for 1 of 1 resident reviewed for wound care. Findings included: Resident #53 was admitted to the facility on [DATE]. She had diagnoses which included congestive heart failure, Diabetes Mellitus and renal insufficiency. Review of Resident #53's hospital discharge instructions dated 4/11/22 read, in part, to apply Medihoney to right heel ulcer. Medihoney is a gel wound dressing. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #53 was cognitively intact and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have no behaviors and to have 1 stage 3 pressure ulcer present on admission, 1 venous ulcer, and 1 surgical wound present on admission. Resident #53's admitting daily skin assessment dated [DATE] read, in part, that resident had a vascular right lateral leg wound. No wound measurements were included. Resident #53's wound care consultant note dated 4/12/22 read, in part, that the right foot was wrapped with kerlix (gauze bandage) with drainage on the bandage. Physician's orders revealed an order dated 4/18/22 for right heel vascular ulcer to be cleansed with wound cleanser, apply silver alginate (an absorbent antimicrobial dressing) and cover with gauze and kerlix wrap every day shift for wound care. Resident #53's Treatment Administration Record (TAR) for April 2022 revealed this order was signed as completed on 4/19, 4/20, 4/21, 4/22. There were no signatures on 4/18 or 4/23. An interview on 6/14/22 at 2:25 PM with the Wound Care Nurse revealed she first observed Resident #53's right heel wound on 4/18/22. She stated she initiated wound care orders and put a note in the Physician's communication book to notify him of the wound. She stated she completed the dressing change for the right heel wound on 4/18/22 and must have forgotten to sign the TAR. The Wound Care Nurse stated she only worked part-time so was unable to say when or if she had seen the wound before or when the dressing had been changed. An interview on 6/16/22 at 9:24 AM with Nurse #2 revealed she was responsible for wound care on 4/23/22 and did not remember if she had changed Resident #53's wound dressings or not. She stated if she had changed the dressing, she would have signed it. An interview on 6/15/22 at 4:29 PM with the Physician revealed he did not remember if he was notified of Resident #53's right heel vascular wound. He stated he expected the facility to follow hospital orders or notify him if they had questions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/15/22 at 3:01 PM with the Director of Nursing (DON) revealed that Resident #53 should have been assessed and wound care orders initiated on admission for her right heel wound. She stated she did not know why her right heel wound had no treatment orders until 4/18/22 or why her wound care treatment had been missed on 4/23/22. An interview on 6/15/22 at 3:33 PM with the Administrator revealed he was not at the facility in April and was unaware of Resident #53. He stated he expected the facility to follow established policies and procedures regarding wound care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200 Based on record review, and staff interviews, the facility failed to maintain accurate medical records for (1) wound care (Resident #53) and (2) splint application (Resident #12) for 2 of 2 medical records review for accuracy. The findings included: 1. Resident #53 was admitted to the facility on [DATE] and died at the facility on [DATE]. She had diagnoses which included congestive heart failure, Diabetes Mellitus and renal insufficiency. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #53 was cognitively intact and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have 1 stage 3 pressure ulcer present on admission, 1 venous ulcer, and 1 surgical wound present on admission. a. Review of Physician's orders revealed an order dated [DATE] for the left foot surgical wound to be cleansed with wound cleanser and apply a dry dressing every day shift for wound care. Review of Resident #53's Treatment Administration Record (TAR) for [DATE] revealed the left foot surgical wound was signed as completed ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and , d+[DATE]. There were no signatures on ,d+[DATE], ,d+[DATE], ,d+[DATE], or ,d+[DATE]. b. Review of Physician's orders revealed an order dated [DATE] for the stage 3 pressure ulcer to the sacrum to be cleansed with wound cleanser and apply skin prep around the wound and silver alginate (an absorbent antimicrobial dressing) and cover with bordered foam dressing every day shift for wound care. Review of Resident #53's TAR for [DATE] revealed the sacrum pressure ulcer wound was signed as completed ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. There were no signatures on ,d+[DATE], ,d+[DATE], ,d+[DATE], or ,d+[DATE]. c. Review of Physician's orders revealed an order dated [DATE] for right heel vascular ulcer to be cleansed with wound cleanser, apply silver alginate and cover with gauze and kerlix wrap every day shift for wound care. Review of Resident #53's TAR for [DATE] revealed the right heel vascular ulcer order was signed as completed on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE]. There were no signatures on ,d+[DATE] or , d+[DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on [DATE] at 2:25 PM with the Wound Care Nurse revealed she first observed Resident #53's right heel wound on [DATE]. She stated she completed the dressing change for the right heel wound on [DATE] and must have forgotten to sign the TAR. The Wound Care Nurse stated she only worked part-time so was unable to say when or if she had seen the sacrum pressure ulcer or left foot wounds before or when the dressings had last been changed. The Wound Care Nurse was unable to say whether or not she had completed the resident's wound care on the days the TAR had not been signed. An interview on [DATE] at 9:24 AM with Nurse #2 revealed she was responsible for wound care on [DATE] and [DATE] and did not remember if she had changed Resident #53's wound dressings or not. She stated if she had changed the dressing, she would have signed it. An interview on [DATE] at 1:43 PM with Nurse #1 revealed she was responsible for wound care on [DATE] and [DATE]. She stated she completed wound care but forgot to sign it. An interview on [DATE] at 3:01 PM with the Director of Nursing (DON) revealed that Resident #53 should have been assessed with documented wound measurements and wound care orders initiated on admission for her right heel wound. She stated she did not know why her right heel wound had no treatment orders until [DATE] or why her wound care treatment had been missed on [DATE]. The DON revealed she expected staff to complete wound care prior to signing as completed. She stated that staff should not sign an order as completed if they had not done so. An interview on [DATE] at 3:33 PM with the Administrator revealed he was not at the facility in April and was unaware of Resident #53. He stated he expected the facility to follow established policies and procedures regarding wound care. 2. Resident #12 was admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #12 had moderately impaired cognition and required limited or extensive assistance for most activities of daily living. Her MDS was also coded to have no behaviors or rejection of care. She was coded to have a right upper extremity impairment on one side. Review of Resident #12's care plan last revised on [DATE] revealed a focus on limited physical mobility related to impaired balance and hemiparesis. This focus had an intervention which included for resident to have a light blue resting hand/wrist splint applied daily for 4 continuous hours as resident allows with a skin inspection before and after splint application. Review of Resident #12's Treatment Administration Record (TAR) for [DATE] revealed an order to apply the right resting hand/wrist splint daily for 4 continuous hours and to inspect the skin before and after the splint application. Further review of the May TAR revealed Nurse #2 had signed this order as completed 8 times. Review of the May TAR also revealed the Wound Care Nurse had signed this order as completed 10 times. There were also 7 days that this splint order had no signature as being completed which were ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE]. Review of Resident #12's TAR for Jun 2022 from [DATE] through Jun 15, 2022, revealed that Nurse #2 had signed the right-hand splint order as completed 7 times, the Wound Care Nurse had signed as completed 4 times, and 1 day with no signature ([DATE]). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #12's nurses' progress notes revealed no documentation that the resident refused to wear the right-hand splint. An observation on [DATE] at 8:14 AM revealed the right-hand splint was laying on the bedside table. An observation and interview on [DATE] at 8:46 AM with Resident #12 revealed she was not wearing her splint. Further observation revealed the splint lying on top of the bedside table and not within the resident's reach. Resident #12 stated the staff did not put the splint on her right hand and she did not refuse to wear the splint. An interview on [DATE] at 11:43 AM with the Wound Care Nurse revealed she had never seen Resident #12's right-hand splint and had never applied it. She was unable to state why she had signed the order as completed on the TAR. She stated that she should have looked for the splint and applied it as ordered. An observation and interview on [DATE] at 9:17 AM with Nurse #2 confirmed that Resident #12 was not wearing a right-hand splint. Nurse #2 stated the resident usually refused to wear the splint. Nurse #2 applied the splint to the resident's right hand and stated, I don't know how to do this. Nurse #2 also stated she did not know why she had signed the order as completed on [DATE], 14, 15, 21, 22, 27, 30 and [DATE], 11, 12. An interview on [DATE] at 3:29 PM with the Director of Nursing revealed she expected staff to complete treatments prior to signing as completed. She stated that staff should not sign an order as completed if they had not done so. An interview on [DATE] at 3:33 PM with the Administrator revealed he was not at the facility in April and was unaware of Resident #12. He stated he expected the facility to follow established policies and procedures regarding physician's orders.