STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. Building B. Wing	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations and staff interviews, the facility: 1) failed to ensure baseboard was in good repair in 1 of 6 resident bathrooms (room [ROOM NUMBER]); 2) failed to maintain a homelike environment in 4 of 31 resident rooms/bathrooms (room [ROOM NUMBER], #204, #301, and #308) observed to have damaged and splintered wooden wall borders and doors, scuff marks and peeling sheetrock on the walls, and holes in the wall and back of a room door; 3) failed to clean a bathroom with a strong odor of urine in 1 of 6 resident bathrooms (room [ROOM NUMBER]) on 3 of 4 resident halls (100 Hall, 200 Hall, and 300 Hall). Findings included: 1. An observation of room [ROOM NUMBER] was conducted on 04/25/22 at 10:20 AM. On the wall, just behind the room door, was a hole in the wall the approximate size of the doorknob. In the bathroom, the baseboard along the entire perimeter had detached from the wall and was lying on the floor. Subsequent observations conducted on 04/26/22 at 5:36 PM and 04/28/22 at 2:27 PM revealed the conditions remained unchanged. An observation of room [ROOM NUMBER] and interview was conducted with the Maintenance Director on 04/29/22 at 3:15 PM. The Maintenance Director stated he wasn't aware of the hole in the wall behind the room door or that the baseboard had detached along the perimeter of the bathroom walls. He stated staff should have notified him of the repairs that were needed so that they could have been fixed. The Maintenance Director explained a clipboard with paper forms were kept at each nurse station for staff to fill out for repairs needed or they could verbally tell either him or the Maintenance Assistant. During an interview on 04/29/22 at 12:54 PM, the Administrator was unaware of the environmental concerns observed in room [ROOM NUMBER] and explained educating staff on completing work orders for maintenance was a work in progress. The Administrator stated she would expect for staff to notify maintenance when repairs were needed. 37538 2. An observation was made on 04/27/22 at 8:33 AM of room [ROOM NUMBER]. A wooden border along the bottom part of the wall had several areas of damaged and splintered wood. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect damaged walls would be reported and repaired timely and for staff to notify maintenance when repairs were needed. An observation and interview were conducted on 04/29/22 at 1:33 PM with the Maintenance Director. The Maintenance Director noted the damaged and splintered wood and revealed it was unsafe and needed to be repaired to prevent the resident from getting a splinter. The Maintenance Director revealed he was not aware of the damage to wood border. 3. An observation of the bathroom in room [ROOM NUMBER] was made on 04/27/22 at 2:20 PM. The lower part of the bathroom wall had multiple black and gray colored scuff marks. There was a dried spackled area of sheetrock left unpainted and multiple crayon marks on the wall beside the toilet. There was an area of peeling sheetrock on the wall in front of toilet. The inside of the wooden bathroom door had multiple splinters and a softball sized hole in lower portion of the door. A wash basin and bed pan were placed directly on the floor under the bathroom sink. An observation and interview were conducted on 04/28/22 at 3:15 PM with Maintenance Director. The Maintenance Director revealed he wasn't aware of the splinters on the bathroom door or damaged areas on the wall and confirmed the door needed to be fixed to prevent the resident from getting a splinter. The Maintenance Director revealed a paper form was kept at each nurse station used to notify of needed repairs. In the morning the Maintenance Assistant (MA) would pick up the forms and initiate repairs. The Maintenance Director stated anyone who noticed a repair was needed could fill out a form or verbally tell either him or the MA. An interview and observation were conducted on 04/28/22 at 3:48 PM with Nurse Aide (NA) #6. NA #6 revealed she hadn't noticed the extent of damage to wood door or sheetrock in the bathroom and had not informed maintenance. NA #6 revealed she wasn't aware of a paper form used report repairs to maintenance but could verbally tell them. An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect damaged doors and walls would be reported and repaired timely. 4. An observation of the bathroom in room [ROOM NUMBER] was made on 04/27/22 at 2:48 PM. The bathroom had a strong odor resembling urine. There was no sign of wetness on the floor. The base of the toilet was discolored with a buildup of black colored debris. The top of toilet bowl was covered with a buildup of debris and lid of the tank had a buildup of dust and both appeared not to be recently cleaned or wiped off. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the bathroom in room [ROOM NUMBER] was made on 04/28/22 at 3:06 PM with the Environmental Service Manager (ESM). The bathroom continued to smell of urine. The base of the toilet continued to have black colored debris and the toilet lid and bowl continued to have a buildup of debris. The ESM confirmed there was odor of urine in the bathroom with no visible sign of wetness on the floor and it appeared the toilet bowl and lid had not been wiped off. The ESM revealed each Housekeeper (HK) was assigned to clean resident rooms each day that included to sweep and mop the bathroom floor and wipe down the surfaces of the toilet. The ESM revealed the HK assigned to clean room [ROOM NUMBER] had left for the day and indicated the bathroom appeared it wasn't swept, mopped, and the toilet was not cleaned. The ESM stated she would expect that was done before the HK left. The ESM revealed she was not aware of the urine odor in the bathroom and if the odor came from underneath the tile flooring it would need to be replaced to get rid of the odor. An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect the resident's bathrooms to be clean and not smell of urine. 5. An observation of room [ROOM NUMBER] was made on 04/28/22 at 3:26 PM with the Maintenance Director. The wall along the side of the bed had multiple areas of black and gray colored scuff marks. The Maintenance Director stated he was not aware of the damage to the sheetrock and indicated the bed was too close to the wall and was causing the damage. An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect damaged walls would be reported and repaired timely.

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to transmit completed Minimum Data Set (MDS) assessments within the regulatory time frame for 6 of 10 sampled residents reviewed for smoking and maintain/improve activities of daily living (Residents #5, #6, #7, #8, #9, and #10). Findings included: 1. Resident #5 was admitted to the facility on [DATE]. Review of Resident #5's electronic medical record revealed a quarterly MDS assessment dated [DATE] was not transmitted to the Centers for Medicare and Medicaid Services until 03/15/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #5's completed quarterly MDS assessment dated [DATE] was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 2. Resident #6 was admitted to the facility on [DATE]. Review of Resident #6's electronic medical record revealed a quarterly MDS assessment dated [DATE] was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #6's completed quarterly MDS assessment dated [DATE] was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 3. Resident #7 was admitted to the facility on [DATE]. Review of Resident #7's electronic medical record revealed a quarterly MDS assessment dated [DATE] was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #7's completed quarterly MDS assessment dated [DATE] was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 4. Resident #8 was admitted to the facility on [DATE]. Review of Resident #8's Electronic Medical Record revealed an annual MDS assessment dated [DATE] was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #8's completed annual MDS assessment dated [DATE] was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 5. Resident #9 was admitted to the facility on [DATE]. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #9's electronic medical record revealed a significant change MDS assessment dated [DATE] was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #9's completed significant change MDS assessment dated [DATE] was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 6. Resident #10 was admitted to the facility on [DATE]. Review of Resident #10's electronic medical record revealed a quarterly MDS assessment dated [DATE] was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #10's completed quarterly MDS assessment dated [DATE] was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.

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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** 37014 Based on observations, record review and staff interviews, the facility: 1) failed to implement interventions by not applying a hand splint as specified in the comprehensive care plan and 2) failed to complete and individualize an activity of daily living care plan for 2 of 3 sampled residents reviewed (Resident #5 and Resident #11). Findings included: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), osteoarthritis, and hand contracture. Review of Resident #5's electronic medical record revealed the following active physician's orders: 07/19/21 read, apply right hand resting splint to be worn during the PM shift and worn throughout the night as tolerated. Check skin around area of splint prior to application at bedtime for contracture management. 07/20/21 read, remove right resting hand splint in AM. Check skin around area of splint after removal one time a day for contracture management. Resident #5's Activity of Daily Living (ADL) care plan, last revised on 07/25/21, addressed an ADL self-care deficit related to stroke, osteoarthritis, and weakness. Interventions included for staff to apply a right-hand resting splint in the PM, remove in the AM and check skin when applying and removing the splint. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #5 with intact cognition. The MDS noted Resident #5 required supervision with eating and extensive to total staff assistance with all other ADL. An observation and interview on 04/26/22 at 5:36 PM, revealed the top part of Resident #5's fingers, on both hands, were bent and curved inward toward the palms with no splint or other device in place. Resident #5 explained staff were supposed to apply a splint to his right hand every night but it hadn't been done. Resident #5 was unable to recall the names of the staff but explained when he asked them about his hand splint, staff told him they did not know where it was. During an interview on 04/29/22 at 9:20 AM, Nurse Aide (NA) #3 revealed she had worked at the facility approximately one month and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. NA #3 voiced she was unaware Resident #5 was supposed to wear a right hand splint during the night and stated she did not recall him ever having one in place when she started her shifts. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/22 at 9:25 AM Nurse #3 revealed she had worked at the facility for approximately one year and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. Nurse #3 confirmed Resident #5 had an order for a right hand splint to be applied every evening and removed every AM. Nurse #3 stated on the days she had provided care to Resident #5 she had not observed the hand splint to be in place for her to remove but she had assessed his skin per the physician's order and noted it on his treatment administration record. Telephone attempts on 04/28/22 at 2:00 PM and 04/29/22 at 9:57 AM for an interview with Nurse #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM, were unsuccessful. Telephone attempt on 04/29/22 at 11:24 AM for an interview with NA #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM was unsuccessful. During an interview on 04/29/22 at 10:33 AM, the Director of Nursing stated it was her expectation for the application of hand splints to be completed per physician's order. During an interview on 04/29/22 at 12:54 PM, the Administrator stated it was her expectation for staff to apply Resident #5's hand splint as specified in his comprehensive care plan.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review and staff interviews, the facility failed to apply a hand splint for contracture management per physician's order for 1 of 1 sampled resident reviewed (Resident #5). Findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), osteoarthritis, and hand contracture. Review of Resident #5's electronic medical record revealed the following active physician's orders: 07/19/21 read, apply right hand resting splint to be worn during the PM shift and worn throughout the night as tolerated. Check skin around area of splint prior to application at bedtime for contracture management. 07/20/21 read, remove right resting hand splint in AM. Check skin around area of splint after removal one time a day for contracture management. Resident #5's Activity of Daily Living (ADL) care plan, last revised on 07/25/21, addressed an ADL self-care deficit related to stroke, osteoarthritis, and weakness. Interventions included for staff to apply a right-hand resting splint in the PM, remove in the AM and check skin when applying and removing the splint. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #5 with intact cognition. The MDS noted Resident #5 required extensive to total staff assistance with most ADL and had no impairment of the upper extremities for functional range of motion. An observation and interview on 04/26/22 at 5:36 PM, revealed the top part of Resident #5's fingers, on both hands, were bent and curved inward toward the palms with no splint or other device in place. Resident #5 explained staff were supposed to apply a splint to his right hand every night but it hadn't been done. Resident #5 was unable to recall the names of the staff but explained when he asked them about his hand splint, staff told him they did not know where it was. With Resident #5's permission, observations conducted of the nightstand, drawers and closet revealed no presence of a hand splint. Subsequent observations conducted on 04/28/22 at 2:27 PM and 04/29/22 at 1:48 PM revealed no hand splint was observed in Resident #5's room. During a follow-up interview on 04/29/22 at 1:48 PM, Resident #5 stated the fingers of his right hand were pliable, his contracture had not worsened and he felt the hand splint did help. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/29/22 at 9:20 AM, Nurse Aide (NA) #3 revealed she had worked at the facility approximately one month and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. NA #3 voiced she was unaware Resident #5 was supposed to wear a right hand splint during the night and stated she did not recall him ever having one in place when she started her shifts. During an interview on 04/29/22 at 9:25 AM Nurse #3 revealed she had worked at the facility for approximately one year and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. Nurse #3 confirmed Resident #5 had an order for a right hand splint to be applied every evening and removed every AM. Nurse #3 stated on the days she had provided care to Resident #5 she had not observed the hand splint to be in place for her to remove but she had assessed his skin per the physician's order and noted it on his treatment administration record. Telephone attempts on 04/28/22 at 2:00 PM and 04/29/22 at 9:57 AM for an interview with Nurse #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM, were unsuccessful. Telephone attempt on 04/29/22 at 11:24 AM for an interview with NA #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM was unsuccessful. During an interview on 04/29/22 at 9:47 AM, the Rehab Manager (RM) explained he had only been at the facility for a few months and had not yet had the opportunity to evaluate the long-term residents for rehab needs. The RM stated Resident #5 had not been on therapy caseload since 2021. The RM stated he was not that familiar with Resident #5 and explained the use of a hand splint would likely be preventative and would not correct or improve his hand contracture. During an interview on 04/29/22 at 10:27 AM, the Medical Doctor (MD) stated she would expect for staff to apply Resident #5's right hand splint the way it was ordered. During an interview on 04/29/22 at 10:33 AM, the Director of Nursing stated it was her expectation for the application of hand splints to be completed per physician's order.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, staff, Resident, Neurologist, Medical Director and Emergency Medical Service (EMS) Paramedic interviews, the facility failed to train a Transportation Aide (TA) to use the securement system during a facility van transport per manufacturer's instructions which resulted in the Resident becoming dislodged from the wheelchair, striking her head on the permanently affixed row of seats then requiring emergency transport to the local hospital for 1 of 1 resident (Resident #1) reviewed for dialysis. Resident #1 was diagnosed with a left temporal subdural hematoma (a condition due to the bleeding under the membrane of the brain usually caused by surgery or injury) that required surgical removal. The facility further failed to train a newly hired Receptionist on the systems in place to prevent a severely cognitively impaired Resident from leaving the facility unattended for 1 of 5 residents (Resident #2) who wandered. Receptionist #1 did not recognize Resident #2 was a resident and opened the door and let him out and when the door alarm sounded the Receptionist did not know what the alarm meant. Resident #2 walked to a nearby sidewalk and lost his balance and fell hitting his head and sustained lacerations to his nose and forehead and was transferred to the local emergency room and received 6 sutures before returning to the facility. The findings included: 1. The undated manufacturer's instructions utilized by the facility and titled, Vehicle Anchorages and Accessories for 4-Point Wheelchair Securement Systems, read in part: Securing Wheelchair: Center wheelchair facing forward in securement zone and apply wheel locks. Attach tie-downs into floor anchorages and ensure they are locked in. Attach the four tie-downs hooks to solid frame members or weldments (near seat level). Ensure tie-downs are fixed at approximately 45 degrees and are within the appropriate angles of 10 inches for the back and 25 inches for the front and locked into place. Tie-downs should never pass through the wheels of the wheelchair and should have a clear path from the floor anchorages to the wheelchair frame. Completely pull out each webbing and attach J-hook to solid frame member. Move wheelchair forward and back to remove webbing slack or manual tension webbing with retractor knobs. Attach retractable combination lap/shoulder belt: attach tongue on end of shoulder belt to buckle stalk closest to the wall. Pull the shoulder belt over occupant's chest and insert tongue into the buckle stalk closest to the aisle. Adjust shoulder belt height so that shoulder belt rests on occupant's shoulder, making sure the shoulder belt does not rub against the occupant's neck. Resident #1 was admitted to the facility on [DATE] with diagnoses of end stage renal disease requiring dialysis three times a week, atrial fibrillation and seizures. Resident #1's quarterly Minimum Data Set, dated dated dated [DATE] indicated the Resident was cognitively intact and was totally dependent on 2 persons for transfers. Resident #1 required a wheelchair for mobility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility reported incident submitted by Administrator #1 on 02/10/22 indicated, Resident #1 was being transported to dialysis on 02/09/22 when there was a van accident. The Resident was first sent to the regional hospital and then sent to a more acute hospital related to a subdural hematoma. The Transportation Aide (TA) was experienced in driving the van but also had a gap in service. The TA was not currently driving (the van), and the transportation had been contracted out. A review of an Emergency Medical Services report dated 02/09/22 revealed the EMS arrived on the scene to find Resident #1 lying in the aisle between two rows of seats. The Resident's head was towards the driver's seat and her legs were wrapped around the last row of seats on the left side. The Resident was lying on her left side with her head on a pillow and complained of left shoulder, bilateral hip and bilateral leg pain. The Resident was assessed to have a hematoma on the left side of her head. The Resident stated she did not believe she was wearing a seatbelt. The report continued to explain that Resident #1 was in a confined spot and difficult to roll over so a cervical collar and pain medication was administered before a pelvic binding apparatus could be applied to the Resident. The Resident was then slid down the aisle to the back of the van and placed onto the stretcher and transported to the local hospital. An interview was conducted with Emergency Medical Services (EMS) Paramedic #1 on 04/29/22 at 10:10 AM. The Paramedic reported she and her partner arrived on the scene of the incident early morning on 02/09/22 and observed the Administrator removing the wheelchair from the van. The Paramedic stated the local fire department had arrived a few minutes before the EMS arrived and had already removed the wheelchair from the hooks and reported the wheelchair was in lock down position when they arrived. The Paramedic explained that Resident #1 had fallen headfirst out of her wheelchair and landed on her left side in the isle between the two rows of seats. She continued to explain that the Resident's head was toward the front of the van and her legs were wrapped around the seat post which caused them concern because they thought her legs might have been fractured. The Paramedic stated Resident #1 had a hematoma on the left side of her head. The Paramedic continued to explain that because of the confined position Resident #1 was lying in, they had to administer pain medication and roll her onto a pelvic apparatus before they could slide her to the back of the van and lift her out of the van and onto the stretcher then transported her to the local hospital. The Paramedic stated that Resident #1 reported several times that she did not believe she was wearing a seatbelt. A review of Resident #1's discharge summary from the local hospital dated 02/09/22 revealed Resident #1 would be transferred to a more acute hospital due to the need for a higher level of care in neurosurgery for a traumatic left subdural hematoma measuring 13 millimeters in thickness and 6 millimeters rightward midline shift. A review of Resident #1 discharge summary dated 03/07/22 from the more acute hospital revealed Resident #1 was admitted to the Neuro Intensive Care Unit on 02/09/22 for a traumatic left subdural hematoma which measured 13 millimeters in thickness and 6 millimeters rightward midline shift. Resident #1 required a craniotomy on 02/21/22 for an increasing left subacute and chronic mixed density subdural hematoma. The Resident remained on the ventilator for two days because of postoperative respiratory failure and was successfully extubated on 02/22/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Resident #1 on 04/24/22 at 4:10 PM. The Resident explained that on 02/09/22 while she was being transported to her dialysis appointment the TA turned left onto Main street and she fell forward then to the right out of her wheelchair and hit her head on the post that held up the row of seats in the back of the van. The Resident continued to explain that the TA did not put the seatbelt or the shoulder strap on her that she just strapped the wheelchair down to the floor of the van, but she didn't realize that she didn't have the shoulder strap or seatbelt on until she had fallen. She stated that the TA was fairly new in driving her to dialysis and she had never had an issue with not being strapped down in the wheelchair before that day. The Resident stated that after she fell out of the wheelchair the TA stopped the van and went back to her and called the Administrator who told her to call 911. The Resident stated the TA stayed with her until the EMS came to her. Resident #1 explained that she had a headache (pointing to the left side of her head) but it did not bleed. The Resident continued to explain that the paramedics took her to the hospital. She stated the hospital ran several CT (computerized tomography) scans on her and discovered she had subdural hematoma on the left side of her head. Resident #1 explained that she was transported to another hospital that was more equipped to treat the subdural hematoma and had to have surgery to remove the hematoma and ended up being admitted to the intensive care unit and remained on the ventilator for several days. The Resident stated she stayed in the hospital until 03/07/22 when she was discharged back to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Transportation Aide (TA) on 04/25/22 at 11:15 AM. The TA explained that she was hired on 01/25/22 to be the TA and the extent of her orientation to the position was the previous Administrator (Administrator #1) taking her out to the van and showing her how to make sure the side mirrors were adjusted correctly for her and that the safety buttons had to be in the correct position before the lift to the van could be raised or lowered. The TA continued to explain that the Administrator sat in the front passenger seat next to her and directed her to drive to the common places where she would be transporting the residents more often such as the dialysis center, the hospitals, the doctor's offices and around town in order to get practice driving the van. She stated that when they returned to the facility, she asked the Administrator when she would receive training on the securement system and the Administrator told her that it will come later. The TA stated that she started to hand the van keys back to the Administrator and he told her to keep them because she was now the van driver and she started that day. The TA stated she could not remember what day that was because she did not write it down but she remembered that later that same day the dialysis center called her and told her that Resident #1 was finished with her dialysis and was ready to be picked up. The TA explained that when she picked Resident #1 up from dialysis she hooked her up to the securement system as best as she could (which she later learned that it wasn't the correct way) and brought the Resident back to the facility without incident. The TA continued to explain that one day, she did not remember which day, she was transporting Resident #1 in the van and the Resident started to slide down out of her wheelchair and she had to stop the van and reposition the Resident back into her wheelchair. The TA stated when she got back to the facility, she asked the Administrator again for orientation on the securement system but was told again that they would get to it. The TA explained that on the morning of 02/09/22 she was transporting Resident #1 to dialysis and she drove over a section of road construction that caused the van to bounce. The Resident stated to the TA that she was sliding out of the wheelchair and the TA looked into the rearview mirror and saw that the Resident was sliding out of her wheelchair. The TA then stopped the van on the road and went back to the Resident but by the time the TA got back to the Resident she had already slid out of the wheelchair and onto the floor of the van but the wheelchair remained in upright position. The TA stated she could not remember how the Resident was lying on the van floor, but she did remember that she put her sweater under the Resident's head and called the previous Administrator #1 and reported what had happened. The TA stated the Administrator instructed her to call 911 so that she could report her location to them which she did, and the EMS arrived within a few minutes. The TA reported that on that same day (02/09/22) the van was taken out of service and was eventually taken to a specialty company to be inspected to make sure the van was in good working condition. She stated she received a detailed training on the securement system which included watching a video, taking a written test and she had to return demonstration to the Maintenance Supervisor (MS) and received a certificate of completion on 02/15/22. She indicated all the training had to be completed before she could resume driving the van for resident transportation. She stated the first transportation she conducted was 02/21/22. The TA expressed that after she received the detailed training on the securement system, she knew that she had not been applying the system correctly when she transported the residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted with Administrator #1 on 04/25/22 at 5:15 PM. The Administrator explained that on the morning of 02/09/22 he was notified by the TA that she was transporting Resident #1 to dialysis and the Resident started to slide out wheelchair when she drove over a section of road construction and by the time the TA stopped the van and went back to the Resident, she had slid out of the wheelchair and onto the van floor. The Administrator stated he instructed the TA to call 911 and let them know her location so they could assist, and he would be there as soon as he could get there. The Administrator stated he arrived about the same time as the EMS. The Administrator continued to explain that Resident #1 sustained a subdural hematoma which required surgery to be removed and was hospitalized for about a month. The Administrator explained that on that same day after the incident he along with the Maintenance Supervisor (MS) from a sister facility had the TA demonstrate to them how she strapped Resident #1 into the wheelchair that morning and after her demonstration and it was determined that the TA did not apply the shoulder strap and the seatbelt properly on Resident #1, the TA only applied the shoulder strap. Therefore, the Administrator stated the Root Cause Analysis (RCA) was determined to be user error. The Administrator stated the MS from the sister facility inspected the van's securement system and it was determined to be in safe working order on 02/09/22. Just for precaution the Administrator explained the van was taken out of service on 02/09/22 and an outside transportation company was utilized until the facility's van was taken to a special mobility van dealership on 02/14/22 for a full safety inspection where again the securement system was determined to be safe and fully functional. The facility van was placed back in service on 02/14/22. The Administrator was asked about the education the TA received on how to drive the facility van and apply the securement system on residents and the Administrator explained that the TA was hired to drive the van because she had prior experience in transporting residents at another facility. He continued to explain that he had previously watched the securement system video and remembered how to apply the securement system so and he oriented the TA on how to drive the van and how to apply the securement system correctly one day before she made her first transport with a resident. The Administrator explained that he had the TA strap him in a wheelchair in the back of the van as if he was the resident and had the TA drive to the most common places that she would frequently be transporting the residents to such as the dialysis center, doctor's offices and hospitals. He stated he did not have the TA watch the securement system video because he did not have the video at the time and did not know how to access it. The Administrator explained that he did not review the TA's driving record before she was hired for the position. He explained that after the incident the TA asked for more training on how to apply the securement system and it was provided. The Administrator explained that the facility purchased the securement system training course and the TA, the MS from the sister facility (who now was the MS at the facility) and himself completed the training on the securement system by watching the video, taking a written test and returned demonstration which they received a certificate of completion. The TA completed the course on 02/15/22 and made her first transport on 02/21/22 and the MS and Administrator completed the course on 02/16/22. The Administrator stated future staff hired to drive the van will be required to complete the securement system course. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/27/22 at 11:20 AM a meeting was held in person with the Transportation Aide (TA), the Director of Nursing (DON) and the previous Administrator (Administrator #1) via telephone. An explanation was given to the parties that there were discrepancies with their account of the type and amount of orientation to the TA position and the utilization of the securement system. The TA repeated her account of the extent of her orientation to the van driving process which was driving the Administrator around town to the frequent places that she would be transporting the residents. The TA was adamant that she was not in-serviced on the securement system until after the incident involving Resident #1 occurred. The TA stated she asked the Administrator several times for in servicing on the securement system but was always told it will come, or it will come later. The Administrator explained that he remembered that he had the TA return demonstration to him on how to properly utilize the securement system and had her drive the van around town to the most frequent places she would be transporting the residents with him as the resident in the wheelchair and strapped down in the back of the van. The Administrator stated after that demonstration on him, he felt that the TA was good to go. The Administrator did not recall the TA requesting additional training on the securement system until after the incident with Resident #1. When the Administrator was asked to explain the differences in the accounts given by himself and the TA the Administrator stated he had a lot going on at the facility at the time of the incident and he explained the situation as best as he remembered it. During an interview with the Director of Nursing (DON) on 04/29/22 at 11:25 AM the DON that she was present in Administrator #1's office one day when the TA stepped into the office and asked the Administrator if she could have training on the securement system in the van and the Administrator told the TA that more training would come later. The DON did not recall the date this conversation occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/25/22 at 1:30 PM an interview was conducted with the Maintenance Supervisor (MS) hired on 02/13/22 who at the time of the van incident on 02/09/22 was the MS at a sister facility. The MS reported that he had over 2.5 years of experience with the securement system in the van having been in charge of the van at his previous employment. The MS explained that he was called to assist the facility on 02/09/22 when the incident happened with Resident #1. The MS continued to explain that the TA, the Administrator and himself met at the van the afternoon of 02/09/22 to conduct a reenactment of how the TA strapped the Resident in the van. The MS explained that as soon as he opened the back door of the van he knew that the procedure had not been conducted properly because the floor anchorages were in the center of the back of the van and not on the side behind the driver therefore, the tie-downs were not applied correctly. The MS stated the wheelchair had to be positioned close to the side of the van in order for the shoulder strap to be applied correctly. He continued to explain that he asked the TA to demonstrate how she applied the seatbelt and the TA positioned the seat belt through the side of the wheelchair panel and he knew instantly that it was not the correct way to apply the shoulder or the seat belt. The MS stated he strapped the Administrator in the wheelchair correctly and drove around the parking lot slamming on the van brakes to demonstrate that if the Administrator stayed upright in the wheelchair then the securement system had been applied correctly which he did. The MS continued to explain that the facility took the van out of service and utilized an outside transportation company to transport the residents. On 02/14/22 he took the van to special mobility distribution and had it serviced and checked out to make sure the securement system was working properly, and the van checked out with no problems. He stated the van was back in service as of 02/14/22. The MS explained that the facility purchased the securement system training course and the TA, the Administrator and himself completed the course which involved watching the video, taking the written test and demonstration and received a certificate of completion before they could drive the facility van. The MS stated anyone designated to drive the van and apply the securement system would have to complete the securement system course before they would be allowed to drive the van and transport a resident. On 04/25/22 at 3:10 PM the Transportation Aide, with the Maintenance Supervisor present, was asked to conduct a reenactment of how the TA applied the securement system to Resident #1 on the morning of 02/09/22. The TA explained that the anchorages and tie-downs were in the center of the van at the time of the incident which meant she had to stretch the shoulder strap too far over to the Resident which prevented her from securing the shoulder strap correctly to the seatbelt and to the Resident. The TA then demonstrated that she had been putting the seatbelt straps through the side panels of the wheelchair instead of putting them straight behind the residents then hooking them to the tie-downs. The TA demonstrated that she had been securing the J-hooks to the outside of the wheelchair frames instead of the insides of the wheelchair frames. The MS then had the TA demonstrate how to apply the securement system according to the manufacturer's instructions. During an interview with the Neurologist on 04/26/22 at 8:55 AM the Neurologist explained that Resident #1 sustained a left temporal subdural hematoma when she fell from her wheelchair during a transportation. The Neurologist stated the Resident did not have to hit her head hard on the surface to cause the subdural hematoma because everybody reacts differently to the impact. He continued to explain that at first, they thought the hematoma would subside but the CT scans showed that the hematoma was growing and she was transferred to a more acute hospital for placement in the Neuro Intensive Care Unit where he managed her condition. The Neurologist explained that Resident #1 underwent a craniotomy to evacuate the subdural hematoma and progressed to discharge back to the nursing facility. He stated he had seen her once in his office since her discharge to remove the sutures and the Resident was doing well from the craniotomy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Medical Director (MD) on 04/27/22 at 3:00 PM. The MD indicated that Resident #1 was hospitalized for approximately a month for a subdural hematoma related to a van incident during transportation to a dialysis session. The MD explained that the Resident was first assessed at a local hospital but was sent to the more acute hospital because of the need for the Neurosurgery unit. The MD stated Resident #1 underwent a craniotomy to remove the subdural hematoma and because of her lungs being in poor condition she remained on the ventilator for a couple of days before she could be successfully weaned from the ventilator. The facility provided the following Corrective Action Plan with a completion date of 02/16/22. The plan of correcting the specific deficiency * The deficient practice of failing to prevent an accident occurred when the facility failed to ensure proper securement of the wheelchair occupant in the facility van. * On 02/09/22 while Resident #1 was being transported to dialysis from the facility via the facility van, the van driver over a metal construction plate in the road, causing the van to bounce. The resident alerted the van driver that she was sliding out of the wheelchair and the van driver responded by quickly stopping the van to assist the resident. The resident had already slid out of the wheelchair before the van driver was able to stop. The wheelchair straps were noted to be secured on all four corners of the wheelchair, however the shoulder and lap restraint failed to keep the resident in the wheelchair. * The van driver immediately called 911 and the facility Administrator. The Administrator arrived at the scene of the incident as emergency medical services (EMS) arrived. The resident was assessed by the emergency medical staff, transported from the scene via EMS and was evaluated by a physician in the emergency room . The resident was admitted to the hospital on 02/09/22. * The investigation of the incident was initiated on 02/09/22 by the Administrator. As a result of a re-enactment of the incident and the van inspection by the Maintenance Supervisor, the facility determined that the incident was related to securement equipment being improperly placed on the resident. A root cause analysis was performed, and it was determined the van driver had been inadequately trained and required additional education. As a result of the incident and of the root cause analysis the following actions were immediately taken: * The facility van was immediately taken out of service after the incident on 02/09/22. * A vendor took over the transport duties for the facility during the investigation. Administrator observed a patient being loaded and properly secured on the vendor's van on 02/10/22. The driver confirmed he had viewed a video on proper securement of wheelchair passengers using the Q-Straint system prior to the transport. Owner reported that all drivers are required to view securement video and perform return demonstration of securement knowledge prior to transporting any wheelchair occupants. Administrator requested that the vendor submit training documentation for operators/drivers from the company owner. * The facility van's entire wheelchair securement system was inspected by the Maintenance Supervisor from a sister facility on 02/09/22. It was determined to be safe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The facility van was taken to a specialty mobility van dealership, special mobility van dealership on 02/14/22 for a full safety inspection. The securement system was determined to be safe and fully functional. * The Medical Director and the family of Resident #1 were notified of the incident on 02/09/22. * On 02/09/22 education was provided to Administrator #1 and the TA by the Maintenance Supervisor from a sister facility. The Maintenance Supervisor will also be responsible to provide education to other designated team members who may operate the facility van to ensure authorized operators have complete knowledge and ability to operate the wheelchair securement system with a return demonstration, and that each is familiar with the facility transport vehicle policy. Staff will not be allowed to drive the van or transport residents until the facility van training is completed and the van is determined to be safe to operate. Newly hired transportation drivers and maintenance staff will also be required to complete training in orientation. * The van was placed back in service on 02/14/22. The Van Driver had the first appointment with the van on 02/21/22. 2. Implementing the plan of correction will be completed through the following actions: * On 02/09/22 the Administrator reeducated the Maintenance Supervisor from the sister facility and the transport driver on the proper application/alignment of the Q-Straint Wheelchair Securement System using the manufacturer's training video, the manufacture's Operator's Manual, and the Facility Transport Vehicle Policy education tools. The Administrator and the transport driver demonstrated competency in using the system to properly secure a wheelchair passenger for transport in the facility van. * The Van Driver completed the Q'Straint video education on 02/15/22. * The Maintenance Supervisor will utilize the transport safety education from the Operator's manual, the manufacturer's training video, and the facility transport Vehicle Policy to educate current and future van drivers. The education will include a return demonstration/competency. Van drivers will not be allowed to drive the facility van until the education is completed. 3. Monitoring the plan of Correction for Compliance with Safety Standards and the policy and procedures for preventing accidents will include the following: * Weekly random boarding/un-boarding observation audits will be conducted by the Maintenance Supervisor/designee who has been trained in the Wheelchair Securement System. * Audits will be presented to the Quality Assurance Performance Improvement (QAPI) Committee Assurance Performance Improvement (QAPI) Committee during monthly meetings for at least 3 months. The plan will be reviewed and revised as needed to maintain compliance. 4. The Administrator will be accountable for ensuring the implementation of this plan of correction. * The Van Driver education was completed on 02/15/22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The van was available for appointments on 02/16/22. * Currently the Van Driver and the Maintenance Supervisor are the only staff members allowed to drive the van. * All immediate actions have been completed or started within the timeline of the Plan of Compliance. The alleges compliance as of 02/16/22. The Corrective Action Plan was validated on 04/29/22 and concluded the facility implemented an acceptable corrective action plan on 02/16/22. The facility provided training to the Transportation Aide, Administrator #1 and the Maintenance Supervisor on the specific securement system utilized in van transportations which was evident by a certificate of completion. The facility van was taken out of service on 02/09/22 and an outside transportation company was utilized until 02/14/22 and the first transportation with the facility van was 02/21/22 which was verified by van logs. The facility van was taken to a special mobility distribution service and the securement system was inspected and was determined to be in good working order on 02/14/22. The Maintenance Supervisor will be the person in charge of orientation of the securement system anyone hired to drive the van and transport the residents. The weekly random boarding and unboarding observation audits were reviewed for accuracy and completion. The audits were presented in the monthly (March/April) Quality Assurance Performance Improvement (QAPI) Committee during monthly meeting by the Administrator with no revisions necessary. 35789 2. Resident #2 was admitted to the facility on [DATE] with diagnoses that included unsteadiness on feet, lack of coordination, difficulty in walking, and repeated falls. Review of a wandering assessment dated [DATE] indicated Resident #2 was low risk for wandering. The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #2 was severely cognitively impaired and required limited assistance with walking in the room and in the corridor. The MDS further revealed that Resident #2 had no behaviors, rejection of care or wandering. Review of an incident report dated 04/22/22 at 4:15 PM by Nurse # 2 read in part, Resident #2 was let out of facility by the staff member assigned to the front desk (Receptionist #1) who didn't realize that he was a resident and had a wanderguard (used to keep wandering resident from exiting facility unattended) in place. The door alarm was sounding when Resident #2 exited the building and began to run across the parking lot as staff was attempting to redirect him back to the facility. Resident #2 lost his balance and fell on the pavement. Staff assisted Resident #2 up and he was able to ambulate back into facility without difficulty. He was noted to have a laceration to his mid nose/ forehead. The Medical Doctor (MD) was notified, and an order was given to send Resident #2 to the emergency room (ER) for evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Receptionist #1's personnel file revealed that she was hired by the facility on 04/17/22. The file revealed no education was given to Receptionist #1 upon hire on the facility's wanderguard system or the door alarms that were present in the facility or what the alarms meant or what to do if the alarm sounded. Receptionist #1 was interviewed on 04/26/22 at 4:39 PM and confirmed that she had worked at th[TRUNCATED]

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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** 37280 Based on observations, record review and staff and Physician interviews, the facility failed to administer oxygen as prescribed by the Physician for 1 of 2 residents (Resident #3) reviewed for oxygen therapy. The finding included: Resident #3 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and heart failure. Resident #3's care plan revised on 07/20/21 indicated the Resident received oxygen therapy related to chronic obstructive pulmonary disease. The goal for Resident #3 to display optimal breathing patterns would be attained by utilizing interventions that included administering oxygen via nasal cannula at the rate ordered by the Physician. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had moderately impaired cognition and required extensive assistance for most of her activities of daily living. The MDS also indicated the Resident required oxygen therapy. A review of Resident #3's medical record revealed an ordered dated 02/22/22 for oxygen to be continuously administered at 2 liters per minute via nasal cannula. An observation was made on Resident #3 on 04/28/22 at 10:45 AM. Resident was lying in bed with the head of the bed at an approximate 30-degree angle. The Resident received oxygen via nasal cannula delivered at 3 liters per minute by an oxygen concentrator which was positioned on the floor on the right side of the bed behind Resident #1's head. The Resident's respirations were even and unlabored at 19 respirations per minute. A second observation made of Resident #3 on 04/28/22 at 2:55 PM revealed the Resident was lying in bed with the head of the bed elevated approximately 30 degrees. The oxygen setting was at 3 liters per minute via the nasal cannula. No acute respiratory distress was noted. On 04/28/22 at 3:00 PM an interview was conducted with Nurse #2. The Nurse explained that she assessed Resident #3 during her morning medication pass and explained that she noted that her vital signs were within normal limits and her oxygen saturation was 96%. The Nurse continued to explain that she checked the Resident's oxygen setting every time she went into her room and the setting was between 2-3 liters per minute. Surveyor requested the Nurse to review the Physician's order for the correct oxygen setting and the Nurse looked at the order and stated the Physician's order for the Resident's oxygen setting should be on 2 liters per minute. On 04/28/22 at 3:05 PM Nurse #2 was asked to accompany the Surveyor to Resident #3's room where the Nurse observed the Resident's oxygen setting was on 3 liters per minute. The Nurse stated she thought it was set at between 2-3 liters and adjusted the oxygen setting to 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing on 04/29/22 at 9:25 AM who expressed that her expectation was that the oxygen should be administered as the Physician ordered. On 04/29/22 at 10:20 AM during an interview with the Physician she explained that her expectation was for Resident #3's oxygen be administered at 2 liters per minute unless the Resident was experiencing an acute respiratory episode then she would expect the Nurse to titrate the oxygen for low oxygen saturations. An interview was conducted with the Administrator on 04/29/22 at 12:55 PM. The Administrator expressed that she expected the residents' oxygen settings be delivered at the prescribed rate given by the Physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 35789 Based on observations and staff interview the facility failed to remove expired medication from 1 of 2 medication carts (300 hall) observed during medication pass and failed to remove expired medication from 2 of 4 medication carts (100 hall and 200 hall) reviewed during medication storage. The findings included: 1. An observation of a medication pass was conducted on 04/26/22 at 9:15 AM with Medication Aide (MA) #1. MA #1 was observed to prepare Resident #13's medications that included Aspirin 81 milligrams (mg) that had an expiration date of 02/22 on the bottle. Once MA #1 had prepared all of Resident #13's medication she locked the medication cart and entered the resident's room to administer the medication. Just prior to the administration MA #1 was prompted to check the Aspirin bottle's expiration date. MA #1 confirmed the Aspirin expired on 02/22, she donned a glove and removed the expired Aspirin from the medication cup and obtained another Aspirin 81 mg that was not expired placed it in the medication cup and again entered the resident room to administer the medication. MA #1 was interviewed on 04/26/22 at 9:20 AM. MA #1 stated, I am sure night shift was responsible for going through the medication carts. She stated that she arrived for her shift this morning and got report and started her medication pass. MA #1 stated she tried to check the medications as she went to ensure none were expired and reorder medications as needed but stated she had not checked the expiration date on the Aspirin bottle prior to entering Resident #13's room to administer her medications. The Assistant Director of Nursing (ADON) was interviewed on 04/29/22 at 11:23 AM who stated that the hall nurses were to check their medication carts daily for expired medications and pull them but with all the agency staff it is very difficult to get them to do anything. The ADON stated that the pharmacy came sporadically but not routinely and helped go through the medication carts. The ADON added that all expired medication should be removed from the medication carts and returned to the pharmacy. The Director of Nursing (DON) was interviewed on 04/30/22 at 11:30 AM. The DON stated that the hall staff should be looking at each medication they administer to ensure that they were not expired. She stated that the facility periodically did cart audits but realistically those were not getting done because they were relying on the hall staff to check them daily. The DON added that the pharmacy was in the facility on 04/25/22 to perform medication cart audits and all expired medication should have been removed from the medication carts. 2a. An observation of the 200-hall medication cart was conducted on 04/28/22 at 11:51 AM along with Nurse #2. The observation revealed the following expired medications that were on the medication cart and available for use: Nephro vitamins 1 opened bottle that expired on 01/22. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clonidine (treat blood pressure) 0.1 mg 28 tablets that expired on 04/09/22. Benzonatate (antitussive) 100 mg 26 tablets that expired on 02/15/22. Nurse #2 was interviewed on 04/28/22 at 12:13 PM. Nurse #2 stated she was not sure who was responsible for checking the medication cart for expired medication but added she had not given those medications. Nurse #2 stated that she tried to go through the medication cart each day she worked but she did not always have the time. Nurse #2 also stated that she had been told the pharmacy had recently been at the facility and she assumed they had removed all the expired medications from the medication cart. 2b. An observation of the 100-hall medication cart was conducted on 04/28/22 at 2:23 PM with Nurse #3. The observation revealed the following expired medications that were on the medication cart and available for use: Ondansetron (antiemetic) 4 milligrams (mg) 20 tablets that expired 01/13/22. Ondansetron 4 mg 6 tablets that expired 01/29/22. Lomotil (treat diarrhea) 2.5 mg 36 tablets that expired 02/26/22. Nurse #3 was interviewed on 04/28/22 at 2:35 PM. Nurse #3 stated that the hall nurses were expected to go through the medication carts and remove any expired medication as they have the time. Nurse #3 stated that she had recently relieved another staff member that had to leave work early and stated she had skimmed through the cart but had not seen the expired medication. Nurse #3 stated that she would take the expired medication and give it to the Assistant Director of Nursing (ADON) so it could be returned to the pharmacy. The ADON was interviewed on 04/29/22 at 11:23 AM who stated that the hall nurses were to check their medication carts daily for expired medications and pull them but with all the agency staff it is very difficult to get them to do anything. The ADON stated that the pharmacy came sporadically but not routinely and helped go through the medication carts. The ADON added that all expired medication should be removed from the medication carts and returned to the pharmacy. The Director of Nursing (DON) was interviewed on 04/30/22 at 11:30 AM. The DON stated that the hall staff should be looking at each medication they administer to ensure that they were not expired. She stated that the facility periodically did cart audits but realistically those were not getting done because they were relying on the hall staff to check them daily. The DON added that the pharmacy was in the facility on 04/25/22 to perform medication cart audits and all expired medication should have been removed from the medication carts.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38515 Based on observations, record review, and facility staff and resident interviews, the facility failed to have sufficient dietary staff to ensure the menu was followed. On 04/24/22 a dietary aide was the only staff member that reported to work and made the decision without consultation from the Dietary Manager or Regional Dietary Manager to serve residents sandwiches for the evening meal. This affected all residents with diet orders. The findings included: An observation of the facility's kitchen was completed on 04/25/22 at 10:22AM revealed 3 staff members in the kitchen. There were two staff members cleaning and 1 running the dishwasher. During an interview with Dietary Aide #1 on 04/28/22 at 12:25 PM, she stated it was routine for there to be only 1 staff member staffed in the kitchen for the dinner meal service, especially on the weekend. During an interview with Dietary Aide #2 on 04/28/22 at 12:53 PM, she reported the kitchen had been short staffed for a while. She stated she had spoken with the Dietary Manager several times about the lack of staff and reported she did not know what, if anything, the Dietary Manager had done to try and hire and schedule more staff. Dietary Aide #2 reported she mainly worked in the mornings but would work some evenings when another dietary aide was off. She also reported she worked the occasional weekend. Dietary Aide #2 reported there had been several times when she was the only staff member in the kitchen for the evening meal and stated When that happens, you have to prep it, cook it, plate it, serve it, do tea and water. It's a lot. She stated when she was the only staff member in the kitchen, meals do not come out on time and are very late getting to the residents. During an interview Dietary Aide #3 on 04/28/22 at 1:16 PM, Dietary Aide #3 reported she had to work by herself the evening of 04/24/22. She stated when she arrived to the facility and realized she was the only staff member in the kitchen, she tried multiple times, unsuccessfully, to reach the Dietary Manager. She stated she looked at the menu and knew she was not going to be able to cook the planned menu and get it to the residents at a reasonable time, so she changed the menu and made chicken salad on lettuce with crackers, and ham and cheese sandwiches with chips. She provided tea, milk, and water to drink. She reported she could not get the Dietary Manager on the phone, so she made the decision to change the meal on her own. During an interview with the Dietary Manager on 04/28/22 at 3:20 PM, she reported she felt there was enough staff scheduled to get the work done timely. She reported there were times when meal trays were a little late to the halls but indicated it was not a routine problem. She also reported not receiving any telephone calls from Dietary Aide #3 on 04/24/22 regarding only one staff member working the evening shift on 04/24/22. She reported she found out on 04/25/22 when she arrived at the building. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Regional Dietary Manager on 04/28/22 at 3:27 PM, he reported there had been some staffing challenges but stated he felt the staffing had gotten better since he became more involved. He stated any call outs should contact the Dietary Manager and fill-ins be notified. He admitted that one staff member for the evening meal would not be ideal, but stated he felt the job could be completed. He stated he thought that one dietary aide should be able to cook, plate, serve, and clean up for the evening meal but admitted if there was only one dietary aide, they would not be able to get the meals out to the hall timely. During an interview with the Administrator on 04/29/22 she reported she was aware of staffing issues within the kitchen and was aware the Dietary Manager did not assist the staff when there were staffing challenges. She stated she has had several conversations with the company the facility contracted with about her concerns with little result. She reported she expected to have sufficient staff in the kitchen to ensure meals were cooked and delivered to the residents timely. She reported Every meal this week has been late and reported she would like 3-4 dietary staff in the kitchen on each shift and that one dietary aide on a shift was absolutely not enough.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38515 Based on record review and facility staff and resident interviews, the facility failed to provide the planned evening meal for residents. This affected all residents who were served an evening meal. The findings included: A review of facility provided menus revealed on 04/24/22 the scheduled evening meal consisted of the following: Country baked pork chops, orange twist, buttered white rice, fried okra, dinner roll, margarine, pineapple tidbits, whole milk, hot coffee or hot tea, creamer, one salt packet, one pepper packet, and one sugar packet. During an interview with an alert and oriented resident on 04/26/22 at 2:32 PM, he reported on Sunday, 04/24/22, he received a ham and cheese sandwich for his evening meal instead of what was on the menu. He could not remember what was scheduled to be served but he knew he did not receive what was originally on the schedule. During an interview with Dietary Aide #3 on 04/28/22 on 04/28/22 at 1:16 PM, she reported when she arrived for her shift in the afternoon of 04/24/22, she realized she was the only dietary staff member working. Dietary Aide #3 stated she was scheduled as the cook for the shift and normally served as a cook when she worked. She stated she tried unsuccessfully to contact the Dietary Manager multiple times to request assistance. She reported she knew she was going to be unable to get the scheduled meal out to the residents in a timely fashion since she was the only staff member in the kitchen, so she changed the evening meal to chicken salad served on lettuce with crackers, or a ham and cheese sandwich with potato chips. She stated she felt the changed menu would be the only meal she could prep, cook, and serve timely. Dietary Aide #3 reported she did not receive approval for the meal changes because the Dietary Manager failed to answer her phone calls. She reported, I was doing the best I could considering I was the only staff member in the kitchen. During an interview with the Dietary Manager on 04/28/22 at 3:20 PM, she reported she did not receive any telephone calls from Dietary Aide #3 on 04/24/22 and indicated that menu changes should not occur unless approved. She stated she was unaware that Dietary Aide #3 worked alone until she arrived at the facility, the morning of 04/25/22. During an interview with the Regional Dietary Manager on 04/28/22 at 3:27 PM, he reported all changes to the scheduled meals should be approved by him or the Dietary Manager and the change should be recorded on the Menu Substitution Log. He also stated that dietary aides should follow the scheduled menu and his company's policy regarding menu substitutions. During an interview with the Administrator on 04/29/22 at 1:56 PM reported the dietary aide should have tried to contact her when she realized she would be working alone in the kitchen. She stated she would have tried to get in touch with the Dietary Manager or the Regional Dietary Manager to try and get more help in the building or come up with an approved menu change. The Administrator stated menus should be followed when possible.

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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** 38515 Based on observations and facility staff interviews, the facility failed to label, and date opened food items in 1 of 1 walk-in refrigerators, and 2 of 2 nourishment room refrigerators, and failed to remove expired food items from 1 of 1 walk-in refrigerators, 1 of 1 reach in refrigerators, and 2 of 2 nourishment rooms, and failed to ensure the walk-in refrigerator and walk in freezer were free from dirt and debris. These practices had the potential to affect food served to residents. The Findings Included: 1. A. During a kitchen walkthrough completed on [DATE] at 10:22 AM an observation of the walk-in refrigerator revealed an opened, undated foam drinking cup of sliced pickles in juice, and a zip closure plastic bag of sliced green peppers that was undated and with milky film, brown water, and black spots. There were also 192 hardboiled eggs with a use by date of [DATE], and 4 unopened 32-ounce containers of thickened dairy drink that expired on [DATE]. B. During a kitchen follow-up visit on [DATE] at 11:56 AM, an observation of the reach-in refrigerator revealed one opened 32-ounce container of thickened dairy drink that expired on [DATE]. During an interview with the Dietary Manager on [DATE] at 11:59 PM, she stated the refrigerators were checked daily and items not dated or expired were removed. She did not know how the named items had been overlooked except by saying that the undated, opened pickles were probably used over the weekend and she had not had a chance to go through the refrigerators on [DATE] when they were found. She indicated there should be no expired food in the facility's refrigerators or freezers. During an interview with the Director of Culinary Services, on [DATE] at 3:27 PM, he reported all opened food items stored at the facility should be labeled, dated, and stored, per their policy. He also reported dietary aides should be checked the refrigerators daily and removing any expired food items. During an interview with the Administrator on [DATE], at 1:56 PM, she reported she expected food items to be labeled, dated, and stored appropriately and that expired food items be removed daily from the facility's refrigerators by either the dietary aides or the Dietary Manager. 35789 2. An observation of the nourishment room just outside of the 700-hall door was made on [DATE] at 11:15 AM with the Dietary Manager (DM) and revealed the following items that were in the refrigerator or freezer and available for consumption: -a frozen chicken and broccoli meal with no name or date on it. -a frozen meatball [NAME] with no name or date on it. -a frozen classic macaroni with beef with no name or date on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-an opened jar of real mayonnaise with no name or open date on it. -2 cups of orange juice with no name or date on it. -chicken salad that contained a first name and 700 hall but no date on it. -a carton of mustard potato salad that expired on [DATE] with no name on it. -a carton of macaroni salad with no name or date on it. -a carton of Chinese takeout food with no name or date on it. -1 pimento cheese sandwich with no name or date on it and the bread was very stiff. -1 peanut butter and jelly sandwich with no name or date on it and the bread was very stiff. -2 chicken salad sandwich with no name or date on it and the bread was very stiff. -a plate of food that contained a resident name with no date on it. -a take out container that had a salad in it with wilted lettuce with no name or date on it. -a box of fried chicken with no name or date on it. -1 bologna sandwich with no name or date on it. -a carton of mustard potato salad that contained a resident name with no date on it that expired on [DATE]. -a classic cob salad that expired on [DATE], the lettuce was covered with a green fuzzy substance. -a container of an unidentified food that had no name but contained a date of [DATE]. There was a fuzzy green substances covering the unidentified food. - an open jug of diet green tea that had no name on it but expired on [DATE]. -2 sandwiches that contained a resident name and date of [DATE]. - an open carton of milk that expired on [DATE]. -carton of thickened milk that expired on [DATE]. -3 cups of yogurt that expired on [DATE]. -2 cup of yogurt that expired on [DATE]. -2 cups of yogurt that expired on [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1 cup of yogurt that expired on [DATE]. The DM was interviewed on [DATE] at 11:31 AM. The DM stated that the Dietary Aides (DA) checked the nourishment room refrigerator and freezer daily, but they were only checking for the items that the dietary department stocked. The other items were the responsibility of the nursing department. The DM was not able to articulate which DA had checked the nourishment room on [DATE]. The DM added that there was no log of the checks it was just a part of their daily routine. The Assistant Director of Nursing (ADON) was interviewed on [DATE] at 11:28 AM. The ADON stated that the dietary department should be checking the nourishment room refrigerator and freezers daily. She added that the nursing department or whoever placed food in the nourishment room would be responsible for labeling and dating the items with a resident name and the date. The ADON stated that the food should be discarded after 3 days by the dietary department when they made their daily check of the refrigerator and freezer. The Director of Culinary Services (DCS) was interviewed on [DATE] at 3:08 PM along with the DM and the Administrator. The DCS stated that the nourishment room refrigerator and freezer should be checked daily and after 7 days the food should be discarded per their policy. The DM again stated that the DA had only been checking the items the dietary department stocked and was unaware that their policy directed them to check all food for expiration dates and discard anything that was 7 days or older. The Administrator stated that the nourishment room refrigerator and freezer should have been cleaned out and any undated or unlabeled food or any expired food should have been discarded by the DAs on their daily checks of the nourishment room. 42090 3. An observation of the nourishment room outside the nurses' station adjacent to the 300 hall with the Administrator on [DATE] at 4:29 PM revealed the following: Items that were sitting at room temperature on the countertop and available for consumption: a 4 quart partially consumed plastic container of applesauce with no label or date 9 cartons of whole milk with an expiration date of [DATE] an opened jar of partially consumed creamy peanut butter with no label or date an opened jar of partially consumed grape jelly an opened carton of partially consumed nutritional supplement an opened cardboard box of sausage biscuits labeled keep frozen Items that were in the freezer that were unlabeled: 2 chicken pot pies an opened partially consumed bag of chimichanga's (continued on next page)

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	345179	A. Building B. Wing	04/29/2022

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Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	an opened box of fruit and banana bites pierced bags of resting on top of a dark brown smeared unidentifiable substance The Administrator was interviewed on [DATE] at 4:30 PM. The Administrator stated the nourishment rooms should be checked daily by the dietary department to discard all unlabeled or undated items as well as out of date items. She indicated the housekeeping department should check the nourishment rooms daily for sanitation. The Director of Culinary Services (DCS) was interviewed on [DATE] at 3:08 PM along with the Dietary Manager (DM) and the Administrator. The DCS stated that the nourishment room refrigerator and freezer should be checked daily and after 7 days the food should be discarded per their policy. The DM again stated that the Dietary Aide (DA) had only been checking the items the dietary department stocked and was unaware that their policy directed them to check all food for expiration dates and discard anything that was 7 days or older. The Administrator stated that the nourishment room refrigerator and freezer should have been cleaned out and any undated or unlabeled food or any expired food should have been discarded by the DAs on their daily checks of the nourishment room. They were unable to determine who placed the food items on the counter and stated all food items that should be refrigerated or kept in the freezer should have been discarded since they were left out on the counter and were room temperature. 39037 4. On [DATE] at 02:52 PM a large amount of a black/brown substance that was easily removable with a paper towel was observed on the walk-in cooler door and the walk-in freezer door. On [DATE] at 09:15 AM a large amount of a black/brown substance that was easily removable with a paper towel was observed on the walk-in cooler door and the walk-in freezer door. An interview with the Dietary Manager on [DATE] at 09:15 AM revealed the evening shift staff was supposed to wipe down the walk-in cooler door and walk-in freezer door daily and if they had been wiping the doors down as they should have been, the black/brown substance would not have been there. The Dietary Manager stated she expected the walk-in cooler door and walk-in freezer door to be clean and free of black/brown substances. An interview with the Administrator on [DATE] at 10:57 AM revealed she expected the kitchen to be clean and free of black/brown substances.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35789 Based on observations, record review, resident and staff interview the facility ' s Quality Assessment and Assurance (QAA) committee failed to ensure regulatory compliance with F880 and failed to maintain implemented procedures and monitor the intervention that the committee put into place on 07/26/21. This was for one repeat deficiency in the area of Infection Control that was originally cited on 06/25/21 during a recertification survey. The continued failure of the facility during the two federal surveys showed a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This citation is cross referred to: F880: Based on observations, record review, and staff interviews, the facility: 1) failed to follow the Special Droplet Contact Precautions signage posted by the door of a resident's room when 1 of 2 nursing staff (Nurse Aide #7) did not don gloves and a gown prior to entering and remove her N95 mask upon exiting 1 of 1 resident room on droplet/contact precautions (Resident #12) and 2) failed to implement their infection control policies and procedures for hand hygiene when Nurse Aide #2 did not remove her gloves and wash hands after providing incontinence care for a soiled resident and before touching other items in the room for 1 of 1 nursing staff observed providing incontinence care to 1 of 1 sampled resident (Resident #4). During the recertification completed on 06/25/21 the facility failed to ensure a COVID-19 positive unit was labeled and personal protective equipment was readily available to staff outside the unit for 1 of 1 COVID-19 positive quarantine units. The facility further failed to ensure staff donned PPE according to the Enhanced Droplet Precautions Isolation sign posted on the door for 1 of 4 residents who resided on the observation quarantine unit. The facility also failed ensure proper glove usage and hand hygiene were completed when a nurse was observed performing a pressure ulcer treatment for 1 of 1 resident reviewed for pressure ulcers. The facility failed to ensure a residents personal clothing was not laundered with a facility incontinence pad for 1 of 1 resident reviewed for laundry. The Administrator was interviewed on 04/29/22 at 3:15 PM who stated that the QA committee included all department heads and the Medical Director. She added that she planned to start inviting some of the direct care staff to come and be a part of the QA process as well. The Administrator stated that they currently had several things in the QA process including infection control and the results of the current complaint investigation would certainly be included in the next QA meeting. The Administrator stated that she had only been back at the facility for a month and had not had the time to get all the processes in place to help the facility achieve and maintain compliance.

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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** 37014 Based on observations, record review, and staff interviews, the facility: 1) failed to follow the Special Droplet Contact Precautions signage posted by the door of a resident's room when 1 of 2 nursing staff (Nurse Aide #7) did not don gloves and a gown prior to entering and remove her N95 mask upon exiting 1 of 1 resident room on droplet/contact precautions (Resident #12) and 2) failed to implement their infection control policies and procedures for hand hygiene when Nurse Aide #2 did not remove her gloves and wash hands after providing incontinence care for a soiled resident and before touching other items in the room for 1 of 1 nursing staff observed providing incontinence care to 1 of 1 sampled resident (Resident #4). Findings included: 1. The Special Droplet Contact Precautions signage, with a revised date of 02/09/22, noted staff should follow the instructions listed on the signage before entering the resident's room which included: all healthcare personnel must: 1) clean hands before entering and when leaving the room, 2) wear a gown when entering room and remove before leaving, 3) wear N95 or higher level respirator before entering the room and remove after exiting, 4) wear protective eyewear (face shield or goggles), and 5) wear gloves when entering room and remove before leaving. The Centers for Disease Control and Prevention (CDC) guidance, last updated 02/02/22, noted in part, Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with SARS-CoV-2 infection if they are not up-to-date with all recommended COVID-19 vaccine doses. Resident #12 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) dated [DATE] assessed Resident #12 with intact cognition. During an observation and interview on 04/26/22 at 1:05 PM, Resident #12 was currently on Special Droplet Precautions (SDCP) and stated he had received the first dose of the COVID-19 primary vaccination series and would be getting the second dose but wasn't sure when. Review of the facility's surveillance line listing for residents and staff revealed on 04/06/22 an outbreak of COVID-19 was identified and new cases continued to be identified on 04/10/22, 04/11/22, 04/12/22, 04/13/22, 04/14/22, 04/18/22, 04/25/22, and 04/28/22. During an observation on 04/26/22 at 12:52 PM, SDCP signage was posted on the wall directly beside the door. Nurse Aide (NA) #7 was observed wearing an N95 mask and goggles when she retrieved a meal tray from the meal cart and entered room [ROOM NUMBER] without donning gloves or gown, placed the meal tray on the bedside table and moved the table closer to the resident. NA #7 then stepped back out into the hall, grabbed a pair of gloves from the Personal Protective Equipment (PPE) container located in the hall beside the room door and returned into room [ROOM NUMBER] to assist the resident with repositioning without donning a gown. Prior to exiting the room, NA #7 doffed her gloves and washed her hands but did not remove her N95 mask after exiting. NA #7 then walked down the hall to the nurses' station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/26/22 at 12:58 PM, NA #7 revealed she had received infection control education related to donning/doffing PPE when entering and exiting resident rooms on isolation precautions. NA #7 confirmed she did not don a gown or gloves prior to entering Resident #12's room and did not doff her N95 mask upon exiting the room. NA #7 explained she did not notice the SDCP signage posted by the room door. During an interview on 04/28/22 at 03:30 PM, the Director of Nursing (DON) stated staff were trained to read the precaution signage and follow the instructions for PPE to be worn. The DON confirmed Resident #12 was on SDCP due to his vaccination status and she would have expected NA #7 to don/doff PPE as instructed on the SDCP signage when entering/exiting the room. The DON added all staff were wearing N95 masks and goggles throughout the facility due to the current COVID-19 outbreak. During an interview on 04/29/22 at 12:54 PM, the Administrator stated all staff were trained on isolation precautions and were expected to follow the instructions for PPE as specified on the signage. 39037 2. Review of the facilty's policy titled Hand Hygiene last revised 10/29/20 read in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. A. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). B. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations. C. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. A continuous observation of Nurse Aide (NA) #2 on 04/26/22 from 11:23 AM to 11:32PM revealed NA #2 provided incontinence care for Resident #4. With gloved hands, NA #2 cleaned stool with resident care wipes and rolled up the soiled brief, dirty sheet, and draw-sheet and tucked it under Resident #4. While wearing the same pair of gloves used to remove stool, NA #2 rolled a clean sheet, clean draw-sheet, and clean brief under Resident #4. NA #2 assisted Resident #4 with rolling onto her right side and then onto her back, fastened the tabs on Resident #4's clean brief, pulled down Resident #4's gown, handed NA #5 a clean pillow case, and assisted NA #5 pull Resident #4 up in bed using the draw-sheet while continuing to wear the same pair of gloves used to remove stool. After Resident #3 was pulled up in bed, NA #2 removed her soiled gloves, discarded them in the trash, and performed hand hygiene. During an interview with NA #2 on 04/26/22 at 11:35 AM she confirmed she did not remove her gloves and perform hand hygiene after performing incontinence care. NA #2 stated she had been trained to remove her gloves and perform hand hygiene after performing incontinence care. She stated she did not discard her gloves and perform hand hygiene when providing incontinence care for Resident #4 because it was an oversight. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 04/29/22 at 10:32 AM revealed she expected staff to remove soiled gloves after performing incontinence care and perform hand hygiene before touching other items. An interview with the Administrator on 04/29/22 at 10:57 AM revealed she expected staff to remove soiled gloves and perform hand hygiene before touching other surfaces.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review, review of the Center for Disease Control and Prevention (CDC) guidance for testing, and staff interviews the facility failed to ensure Health Care Personnel (HCP) not up to date with their Covid-19 vaccine were tested twice a week based on the community transmission levels and failed to ensure HCP were tested prior to reporting to their work area for 3 of 3 staff reviewed for infection control (Nurse #6, Nurse #7, and Nurse #3). This occurred during the Covid-19 pandemic. The findings included: Review of the CDC guidance last updated 02/02/22 titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-Cov-2 Spread in Nursing Homes for expanded screening testing of asymptomatic HCP read in part: In nursing homes, HCP not up to date with all recommended Covid-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: nursing homes located in counties with substantial to high community transmission levels HCP should have a viral test twice a week. If HCP work infrequently ideally testing should be done within 3 days before their shift. Review of the facility's policy titled; Coronavirus Testing last reviewed/revised on 03/10/21 read in part: Testing of HCP who are not up-to-date with all recommended Covid-19 vaccine doses continue expanded screening testing twice a week when community transmission levels were substantial or high. Review of the facility's surveillance line list for residents and staff revealed on 04/06/22 an outbreak of Covid-19 was identified, and new cases continued to be identified on 04/10/22, 04/11/22, 04/12,22, 04/13,22, 04/14/22, 04/18/22, 04/25/22, and 04/28/22. Review of the CDC tracking of community transmission levels for the facility revealed Covid-19 levels were high for the weeks of 04/18/22 and 04/25/22. a. Review of facility's Covid-19 testing log revealed on 04/19/22 Nurse #6 tested negative. The next test results dated 04/26/22 and 04/27/22 and were negative. There were no other test results prior to 04/19/22. During an interview on 04/26/22 at 12:44 PM Nurse #6 confirmed she was not up to date with the Covid-19 vaccine and received the first and second dose but not the booster. Nurse #6 revealed she had only worked a couple of shifts at the facility and the facility provided testing twice a week on Monday and Thursday. Her most recent test was last Thursday on 04/19/22 and she was negative. Nurse #6 revealed she didn't work on 04/25/22 this past Monday the scheduled testing day and had not been tested prior to reporting to her work area on 04/26/22. Nurse #6 revealed her assignment for today was to provide care for approximately eleven residents. Nurse #6 also revealed her last shift on 04/19/22 was on the Covid-19 unit designated for positive residents. Nurse #6 revealed she forgot to be tested this week prior to reporting to her work area. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/26/22 at 3:18 PM the Director of Nursing (DON) revealed she was the designated Infection Preventionist and stated staff were expected to test twice a week on the scheduled testing days Monday and Thursday. The DON revealed after she was made aware Nurse #6 was not tested on Monday, she was immediately tested on [DATE] and received a negative result. b. Review of facility's Covid-19 testing log revealed Nurse #7 had received a negative test result on 04/26/22 and 04/27/22. There were no other test results prior to 04/26/22. An interview was conducted with Nurse #7 on 04/26/22 at 12:48 PM. Nurse #7 confirmed she was not up to date with the Covid-19 vaccine and had received the first and second dose but not the booster. Nurse #7 revealed she worked for an agency staffing company and had worked at a different facility and tested negative for Covid-19 on 04/23/22. Today, 04/26/22 was her first day back and she had not been tested this week. Nurse #7 revealed the facility provided testing twice a week on Monday and Thursday and she was not aware she needed to be tested prior to reporting to her work area. Nurse #7 revealed her assignment was to provide care for approximately eleven residents. During an interview on 04/26/22 at 3:18 PM the Director of Nursing (DON) revealed she was the designated Infection Preventionist and stated staff were expected to test twice a week on the scheduled testing days Monday and Thursday. The DON revealed after she was made aware Nurse #7 was not tested on Monday, she was immediately tested on [DATE] and received a negative result. c. Review of facility's Covid-19 testing log revealed Nurse #3 received negative test result on 03/22/22, 03/29/22, 04/05/22, 04/12/22, 04/15/22, 04/19/22. There were no test results from 04/20/22 through 04/25/22. An interview was conducted with Nurse #3 on 04/27/22 at 11:57 AM. Nurse #3 revealed she was fully vaccinated and had no symptoms of Covid-19. Nurse #3 revealed the facility tested staff twice a week on Tuesday and Thursday and her test last week was negative. Nurse #3 revealed she worked this past Monday on 04/25/22 and didn't test but would today being it's Tuesday the day staff were scheduled to test. During an interview on 04/26/22 at 3:18 PM the Director of Nursing (DON) revealed she was the designated Infection Preventionist and stated staff were expected to test twice a week on the scheduled testing days Monday and Thursday. The DON revealed either her or the Assistant Director of Nursing (ADON) tested staff for Covid based on the daily schedule. During an interview on 04/27/22 at 2:03 PM Nurse #3 revealed she was tested for Covid-19 and received a negative result. An interview was conducted with Administrator on 04/29/22 at 12:53 PM. The Administrator stated the facility was currently in outbreak status and staff were expected to test twice a week based on the CDC community transmission levels. The Administrator revealed it was her expectation staff test on either on the scheduled test days or if not present prior to reporting to their designated work area.

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 37014 Based on observations, record review and staff interviews, the facility failed to implement the facility's process for tracking COVID-19 vaccination status for 17 of 21 contract staff reviewed for vaccinations (Nurse #8, Nurse #9, Nurse #10, Nurse #11, Nurse #12, Nurse #13, Nurse Aide (NA) #2, NA #5, NA #8, NA #9, NA #10, NA #11, NA #12, NA #13, NA #14, NA #15, and NA #16). The facility was currently in outbreak status. Findings included: The facility's Employee COVID-19 Vaccination Mandate Policy with a reviewed/revised date of 12/28/21, read in part: it is the policy of the facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State, and local guidelines. Compliance Guideline #2: Employees who provide any care, treatment or other services for the facility and/or its residents regardless of clinical responsibility or resident contact are required to be fully vaccinated against COVID-19 and include the following: facility employees, licensed practitioners, students, trainees, volunteers, and individuals under contract or by any other arrangement. The facility will track and securely document the vaccination status of each staff member (current and as new employees are onboarded) to include vaccination dates and copies of vaccination records. Review of the facility's surveillance line list for residents and staff revealed on 04/06/22 a COVID outbreak was identified and 22 residents had tested positive for COVID-19 as of 04/28/22. The facility COVID-19 staff vaccination spreadsheet provided by the Administrator on 04/25/22 was reviewed and compared to the 04/25/22, 04/26/22 and 04/27/22 daily staff schedules. The spreadsheet included in-house staff and contract/agency staff. There were 21 nursing staff listed on the daily schedules that were not included on the vaccination spreadsheet provided by the Administrator. A review on 04/26/22 of the National Healthcare Safety Network (NHSN) data for the week ending 04/10/22 revealed the following: Recent Percentage of Staff who are Fully Vaccinated = 100% (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	During interviews on 04/26/22 at 3:20 PM and 04/28/22 at 4:01 PM, the Administrator revealed she was the one currently keeping track of staff vaccination status. The Administrator explained vaccination cards were obtained upon hire for facility staff and the Staffing Agencies the facility utilized were supposed to send her copies of contract staff vaccination cards. Once the information was received from the Staffing Agency, she tried to organize them alphabetically in a notebook per agency. The Administrator added she also tried to keep the vaccination spreadsheet updated with the current vaccination information; however, she wasn't always able to update it daily or as soon as the copy of the vaccination card was received. Upon review of the staff vaccination spreadsheet and daily staff schedules for the period 04/25/22 to 04/27/22, the Administrator looked through the vaccination notebook and was able to provide copies of the vaccination status for 4 of the 21 facility and contract staff who were listed as working on the daily staffing schedules but was not included on the vaccination spreadsheet. The Administrator confirmed she was unable locate any paperwork regarding the remaining 17 contract staff vaccination status. The Administrator stated she had to reach out to the Staffing Agencies to obtain the missing information, as she had found some holes in the process, and now had all the vaccination information for facility and contract staff. The Administrator provided the information for the remaining contract staff which showed they had received all doses of the COVID-19 vaccination.