STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A unannounced complaint investigation was conducted onsite on 10/20/20 and 10/22/20 and offsite on 10/21/20 and 10/23/20. The survey resulted in 3 of the 7 complaint allegations substantiated resulting in federal deficiencies. See Event # OBYH11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		11/9/20

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

Electronically Signed | 11/09/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and residents the facility failed to maintain dignity by not covering the urinary drainage bags to prevent the bag's contents to be viewed by others for 3 of 3 residents (Residents #3, #7, and #8) reviewed for urinary catheter care. Findings included: 1. Resident #8 was admitted to the facility on 4/17/2019 with diagnoses that included intervertebral disc degeneration and neurogenic bladder. The resident's most recent quarterly Minimum Data Set (MDS), dated 10/21/2020, revealed Resident #8 had functional vision and hearing and could make his needs known to others. The resident was cognitively intact without moods or behaviors. Resident #8 was reported to require one-person physical assistance for activities of daily living and personal hygiene. The resident had and indwelling catheter and ostomy during the assessment period. On 10/22/2020 at 9:30am Resident #8 was observed in the hall seated in his wheelchair with	F 550	F-550 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 11/06/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff regarding resident rights and that all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 a urinary drainage bag hanging under his chair, easily viewed by others. The drainage bag was not covered and urine was observed in the bag. On 10/22/2020 at 9:30am an interview was conducted with Resident #8. The resident stated he usually has a cover on his bag and he would like a cover on his bag. He further stated he has had blood in his urine in the past and would be embarrassed if anyone had to see that. Resident #8 stated when the last cover fell off, he was told by nursing staff there were no more covers in the facility, but they had been ordered. He could not remember when that conversation took place or with which staff member told him there were not covers in stock. He stated it had been at least a week since he had a cover on his urinary drainage collection bag. On 10/22/2020 at 11:00am an interview was conducted with the unit manager. She stated there were covers for the urinary drainage collection bags in the facility and she was not certain why they were not being utilized. On 10/22/2020 11:35am an interview was conducted with Nurse #3. He stated he was assigned to Resident #8 from 7:00am until 7:00pm. When asked about a cover for his urinary drainage bag, the Nurse stated he was an agency nurse and was not sure why Resident #8 did not have a cover on his urinary drainage bag and he was not sure if the facility had any for use. On 10/22/2020 at 1:00pm the resident was observed seated in his wheelchair by the entrance with a cover over his urinary drainage collection bag.	F 550	urinary drainage bags must always have a privacy cover placed over them. For affected resident(s): Residents #3, #7, and #8 all had privacy covers placed over their urinary drainage bags effective 10/22/2020 and thereafter. For other residents with the potential to be affected: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: On 11/06/2020 the Administrator and the Director of Nursing initiated re-education to all staff regarding resident rights and the need to have a privacy cover placed over all urinary drainage bags at all times. Facility plan to monitor its performance to make sure that solutions are sustained: An audit sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents with a urinary drainage bag will have the appropriate privacy covering. This monitoring process will take place daily (M-F) for 3 weeks, weekly for 3 weeks, then monthly for 3 months. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 An interview was conducted with the DON and the facility administrator on 10/23/2020 at 2:00pm. Both the DON and the administrator stated it was their expectation residents have privacy covers over urinary collection bags to maintain their dignity. 2. Resident #7 was admitted to the facility on 11/21/2017 for diagnoses that included metabolic encephalopathy and neurogenic bladder. Resident #7's most recent annual Minimum Data Set (MDS), dated, 10/9/2020, revealed the resident had functional hearing and vision and could make her needs known to others. The resident had mild cognitive impairment but could understand others and be understood by others. Resident #7 was coded as needing physical assistance with activities of daily living and personal hygiene. On 10/22/2020 at 9:43am resident #7 was observed in the hall just outside of her room. She had an uncovered urinary catheter bag hanging on the bottom left side of her wheelchair which contained urine. When asked, the resident stated she did want a cover over her urinary drainage collection bag and she was not sure why she did not have one. She could not state how long she had gone without a cover. The resident stated she could not see the bag once it was placed under her wheelchair but she knew other people could and she did not like that people could see her urine. On 10/22/2020 at 11:00am an interview was conducted with the unit manager. She stated there were covers for the urinary drainage collection bags in the facility and she was not	F 550	any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/9/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4	F 550		

certain why they were not being utilized.

An interview was conducted on 10/22/2020 at 11:40am with the treatment nurse who was also assigned to Resident #7. The treatment nurse stated she did not know why the resident did not have a cover on her urinary collection bag but the NA on the hall would know.

An interview was conducted on 10/22/2020 at 11:42am with NA #6 who stated she was assigned to Resident #7. She stated she did not know why the resident did not have a cover on her urinary drainage collection bag.

An interview was conducted with the DON and the facility administrator on 10/23/2020 at 2:00pm. Both the DON and the administrator stated it was their expectation residents have privacy covers over urinary collection bags to maintain their dignity.

3. Resident #3 was admitted to the facility on 9/14/2020 with diagnoses that included intellectual disability and stage four pressure ulcer of the sacrum.

The resident's admission Minimum Data Set (MDS), dated, 9/12/2020, indicated the resident was severely cognitively impaired, and required extensive assistance with all activities of daily living and personal hygiene.

On 10/20/2020 at 11:35 am Resident #3 was observed in her bed with a urinary drainage collection bag easily visible from the hall. The bag was not covered and contained urine.

While observing wound care for Resident #3 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

10/20/2020 11:00am it was bought to the attention of the DON and the treatment nurse who were conducting the wound care, that the resident did not have a cover on the urinary drainage bag that could be seen from the hall. The Director of Nursing (DON) stated they would get a privacy cover for the resident's drainage bag.

On 10/22/2020 at 9:43am a second observation revealed the urinary drainage collection bag did not have a cover and was easily visible from the hall. The resident's drainage bag was observed to contain urine.

On 10/22/2020 at 11:00am an interview was conducted with the unit manager. She stated there were covers for the urinary drainage collection bags in the facility and she was not certain why they were not being utilized.

An interview was conducted on 10/22/2020 at 11:40am with the treatment nurse who was also assigned to Resident #3. The treatment nurse stated she did not know why the resident did not have a cover on her urinary collection bag but the NA on the hall would know.
An interview was conducted on 10/22/2020 at 11:42am with NA #3 who stated she was assigned to Resident #3. She stated she did not know why the resident did not have a cover on her urinary drainage collection bag.

An interview was conducted with the DON and the facility administrator on 10/23/2020 at 2:00pm. Both the DON and the administrator stated it was their expectation residents have privacy covers over urinary collection bags to maintain their dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff and Physician interviews and record review, the facility failed to prevent a resident from being physically restrained with a sheet tied to his wheelchair (Resident #5). The facility also failed to reassess	F 604	F-604 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of	11/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 7	F 604		

for the continued need of a restraint (pommel cushion) and attempt a restraint reduction (Resident #4 and Resident #6). This was for 3 of 3 residents reviewed for restraints. The findings included:

1. Resident # 5 was admitted on 11/18/19 with a diagnosis of Alzhimer's Disease.

His quarterly Mimimum Data Set (MDS) dated 9/15/20 indicated severe cognitive impairment, physical behaviors, rejection of care and wandering. The MDS was coded for no falls since previous assessment.

Resident #5's fall care plan dated 9/23/19 read he was a high risk for falls due to his confusion and lack of safety awareness. The intervention read increased staff monitoring.

Review of an incident note dated 10/12/20 at 11:30 am read Resident #5 was noted sitting at a table in the common room with a sheet tied securely around his waist to the wheelchair. Resident #5 was alert and answering questions and not voicing any pain or discomfort. The sheet was removed. There was no redness and his abdomen was soft and non-tender.

Review of Resident #5's behaviors care plan initiated on 11/20/19 behaviors care plan read he exhibited combativeness, verbal and physicial behaviors toward others and a behavior of pushing tables around the locked unit. The care plan was revised on 10/13/20 read he repeatedly gets up and down in the wheelchair, would go over his wheelchair armrest and was a high fall risk. Interventions included staff intervening as necessary to protect the rights and safety of

correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

Root Cause:
The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 11/06/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the staff regarding the proper process for restraint usage, the continued need for a restraint with supporting documentation, and an attempt of a restraint reduction.

For affected resident(s):
Resident #5 had the sheet removed by the unit manager upon discovery on 10/12/2020. Resident #4 had a restraint reassessment and reduction attempt on 10/28/2020. Resident #6 had a restraint reassessment reduction attempt on 10/27/2020.

For other residents with the potential to be affected:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 8 others, divert attention, remove from the situation and to take him to an alternate location as needed. Review of the facility's 5-day Investigation Report dated 10/16/20 submitted to the state agency read as follows: the allegation of abuse was unsubstantiated. On the morning of 10/12/20, the aide coming in of first shift discovered Resident #5 had a sheet around his waist and tied to his wheelchair. The aide alerted management and the sheet was removed. He had the ability to maneuver his wheelchair and get to his body. He was assessed for injuries. There was no noted physical or emotional changes and he remained at his baseline physically, emotionaly and mentally. At the conclusion of the facility's investigation, it was determined that there was no ill intent by attempting to keep Resident #5 safe. The facility's investigation was also unable to determine the responsible person with any degree of certainly but suspended Nurse #1 and Nursing Assistant (NA) #2 pending the conclusion of the investigation. Nurse #1 was allowed to return to work after the investigation but NA #2 was an agency aide and did not return to work at the facility. The facility contacted the police department who responded onsite on 10/12/20. Resident #5's Responsible Party (RP) was notified on 10/12/20 at 11:36 AM. The facility provided evidence of their investigation to include staff interviews on 10/11/20 on second shift through first shift on 10/12/20. The facility's root cause anaylisis determined the staff required education on techniques regarding how to keep a resident safe. Corrective action included immediate re-education regarding abuse, restraints and techniques that could be utilized to maintain resident safety while mobile. Review of	F 604	stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: On 11/6/2020 the Administrator and the DON initiated re-education to the nursing staff regarding the proper process for restraint use that includes the need for a restraint reassessment and reduction attempt along with supporting documentation. On 11/6/2020 the Administrator and the DON initiated re-education to the MDS staff regarding the need for accurate coding on the MDS to reflect the use of a restraint. Facility plan to monitor its performance to make sure that solutions are sustained: An audit sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents are free from unnecessary restraints, accuracy of MDS coding of restraints along with supporting documentation, and that a restraint reassessment and reduction has been attempted at least quarterly. This monitoring process will take place daily (M-F) for 3 weeks, weekly for 3 weeks, then monthly for 3 months. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 9 the facility's corrective action revealed evidence of staff re-edication on abuse and restraints and evidence the facility terminaited the employement on NA #2 and reported the incident to the Health Care Registry. The 24 Initial Report and 5-day Investigation Report were submitted timely. A telephone interview was conducted with Nurse #1 on 10/21/20 at 1:17 PM. She stated that she worked the 11-7 shift on 10/12/20. She recalled giving report to Nurse #2 on 10/12/20 and then left work. She stated when she got home, the facility called to ask her why Resident #5 was tied into his wheelchair with a sheet. Nurse #1 stated she had no idea that he had a sheet tied around him. She recalled ealier on the 11-7 shift, Resident #5 was sitting in the common area in his wheelchair. Nurse #1 stated Resident #5 seldom slept at night and was up and down frequently. She stated at the beginning of the shift, Resident #5 was constantly standing up from his wheelchair and attempting to walk. She stated she recalled medicating him with a as needed dose of Lorazepam (antianxiety) gel early in the shift. Nurse #1 stated his Lorazepam gel was seldom effective and Physician #1 was aware. She recalled assisting NA #2 with pulling Resident #5 up in his wheelchair sometime after 1:00 AM she thought but not sure. She stated he was unable to walk and he had fallen numerous times. Nurse #1 stated Resident #5 needed 1:1 observation to prevent him from falling and injuring himself but she did not report her concerns to Unit Manager (UM) #1 or the Director of Nursing (DON). Nurse #1 recalled giving Resident #5's his medications around 5:45 AM while he was sitting in the common area. She recalled him dozing but he was easiliy arroused. She stated she did not notice a sheet tied around	F 604	modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/9/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 10	F 604		

his waist. She stated to her knowledge, it may have happened sometime after that. She stated NA #2, NA #1 and NA #3 were working with her on the night of 10/12/20. She stated NA #2 was an agency aide and she only worked in the locked unit a few times. She stated NA #1 and NA #3 worked for the facility and had worked in the locked unit for "along time". Nurse #1 stated she was unsure who was assigned Resident #5 the night of 10/12/20 because the aides liked to work together to care for everyone. She confirmed she was suspended and the facility re-educated staff on abuse and restraints.

A telephone interview was conducted with NA #2 on 10/21/20 at 1:27 PM. She confirmed she no longer worked at the facility and was an agency employee. She stated she was assigned to work 11-7 in the locked unit on 10/12/20. NA #2 stated she asked NA #3 what assignment she wanted her to take and NA #3 stated she preferred to work together but stated NA #3 was assigned Resident #5. She stated she helped NA #3 toilet Resident #5 at the beginning of the 11-7 shift and helped pull him up in his wheelchair with Nurse #1 but was unsure of time. NA #2 stated she did not tie Resident #5 into his wheelchair with a sheet. She stated Resident #5 was constantly attempting to get up out of his wheelchair and trying to walk when she worked in the locked unit. NA #2 stated she did not chart on anyone on 10/12/20 because she was unsure of her assignment but NA #3 was assigned Resident #5.

A telephone interview was conducted with NA #1 on 10/21/20 at 2:24 PM. He confirmed he worked 11-7 shift in the locked unit on 10/12/20. NA #1 stated NA #2 was assigned Resident #5. NA #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 11	F 604		

recalled seeing Resident #5 sitting in his wheelchair at a table in the common area near the nursing station when he came in. He said it was not uncommon for Resident #5 to refuse to sleep in his bed preferring to sit in the common area and nap. NA #1 recalled seeing Resident #5 attempting to stand up and sit back down in his wheelchair several times in the eariler part of the shift on 10/12/20. He stated NA #2 and NA #3 were watching Resident #5 because he frequently got up and attempted to walk but was unsafe and had experienced numerous falls.

A telephone interview was conducted with NA #3 on 10/21/20 at 2:28 PM. She stated she had worked at the facility for 10 years and Resident #5 was on her assignement on 10/12/20. She stated she often assisted the staff on the main floor with their incontinence rounds if things were quiet on the locked unit. NA #3 stated at the beginning of the 11-7 shift on 10/12/20, NA #2 assisted her with toileting Resident #5. She stated if he was toileted at the beginning of the shift, he would not need to go to the bathroom again until the morning. She stated it was at this time when she tried to put him to bed but he refused so she put Resident #5 into his wheelchair and wheeled him to the common area. NA #3 stated he had insomnia and did not sleep much at night but rather dozed while sitting up in his wheelchair in the common area. She recalled on 10/12/20 around midnight, she told Nurse #1 she was going to assist the staff on the main floor with their incontinence rounds. She stated Resident #5 was the only resident still up and NA #2 agreed to watch him. She recalled that as she was walking up the hall to exit the locked unit when she heard something and looked around to see Nurse #1 and NA #2 trying to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 12	F 604		

Resident #5 from sliding out of his wheelchair in the common area. NA #3 stated it was around 12:30 am or 1:00 AM when she returned to the locked unit and saw Resident #5 sitting up in his wheelchair in the common area and never saw a sheet tied around him. She stated she did not try again to put Resident #5 in bed because she knew him and he would not do it. She stated after she left work, she got a text from a co-worker who told her about the sheet round Resident #5. She stated she called NA #2 and asked her if she knew anything about the sheet and NA #2 responded by saying "Oh ****". She stated she did not see Resident #5 attempting to get up anytime after she returned to the unit from assisting up front.

An interview was conducted with NA #4 on 10/22/20 at 9:45 AM. She stated she was the aide who discovered the sheet tied around Resident #5's waist to his wheelchair on 10/12/20. She said he was sitting in the common area near the waist high ¼ wall near the end of the common area. She stated his wheelchair brakes were unlocked and he was awake. She recalled pushing him to the nurses station for Nurse #2 to see. She stated the sheet was not visable from the front. She stated Nurse #2 notified the DON. She stated after the sheet was removed, she assisted Resident #5 with his activites of daily living (ADLs). NA #4 stated his brief was wet but not saturated and he was coorpertive with her. She stated Resident #5 was combative and resisited assistance often. She confirmed re-eucation on abuse and restraints. NA #4 stated it was never normal practice to tie a sheet around a resident. She stated she worked with Resident #5 daily on first shift and she had not noticed any evidence of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 13	F 604		

physical or mental/emotional adverse effects as a result of the incident.

A telephone interview was conducted with Nurse #2 on 10/21/20 at 4:24 PM. She stated she worked first shift on 10/12/20 and relieved Nurse #1. She stated Nurse #1 did not say much about Resident #5. Nurse #2 stated shortly after Nurse #1 left, NA #4 brought him up to the nurses station and asked her if she saw anything unusal. NA #4 then turned his wheelchair around and saw the sheet tied to his wheelchair. She looked and noted his shirt was pulled down in front and unless you turned him around, you would not see the sheet. She sent NA #4 up to front to get UM #1 and the (DON). Nurse #2 stated UM #1 removed the sheet and assessed him for any injuries such as brusing and red marks. The DON attempted to assess his mental status to see if there was evidence of emotional or mental changes as a result of being restrained but due to his poor cognition, it was difficult to assess. She stated she continued to montitor Resident #5's physical, mental and emotional status the reminder of first shift and did not note any changes.

An interview was conducted with UM #1 on 10/22/20 at 9:20 AM. She stated Resident #5 was being followed by psychiatric services and his behavior of standing up from his wheelchair and trying to walk started in the last few months. She stated he had COVID-19 in August and the behaviors seemed to have worsened after that. It was at that time the the psychiatrist put him on the Lorazepam gel. The psychiatrist did a telehealth visit on 9/24/20 with no new orders. She stated on the morning of 10/12/20, Nurse #2 called her to the locked unit. She stated when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 14	F 604		

she looked at Resident #5, she could not see the sheet unless he was turned around. She stated she got the DON and they removed the sheet and completed a physical assessment but were unable to assess his psychological status due to his advanced Alzheimer's Disease. UM #1 stated Nurse #1 and NA #2 were suspended due to suspicions related to the way the sheet was tied to Resident #5's wheelchair. She described the knot tied in the sheet as "old school" but did not elaborate on what this meant. She stated Resident #5 was a very difficult resident and he required 1:1 observation while he was awake because of his behavior of continously trying to get up and walk but he was unable to phsycially do so anymore. UM #1 stated Physician #1 and his RP were both notified of the incident. She stated Resident #5's medications precribed for his behaviors were "hit or miss" and they worked but it took awhile for the medications to take effect. UM #1 stated she did not think anyone tied Resident #5 into his wheelchair to punish him or for convienience but rather out of despiration to prevent him from falling and injuring himself. She stated his RP was not upset at all and stated it was fine with if they needed for restrain Resident #5. She stated she explained to the RP that the staff would not be doing that and it was wrong that it happened.

An observation of Resident #5 was conducted on 10/22/20 at 9:35 AM. He was observed sitting in his wheelchair at a table in the common area. He appeared to be sleeping but was easliy aroused. His cognition was very impaired. There was no observed physical injuries and surveyor unable to determine any mental or emotional adverse reactions to the incident that occurred on 10/12/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 15	F 604		

A telephone interview was conducted with Physician #1 on 10/22/20 at 3:23 PM. Physician #1 stated Resident #5 was a very high risk for falling with possible injury and had experienced multiple falls while at the facility. She stated Resident #5 started exhibiting an increase in behaviors in August when he was diagnosed with COVID-19. She stated the staff had been through a lot with the COVID-19 outbreak, the staff were tired and the facility had been using transiant staff. Physician #1 stated she felt someone applied the sheet to Resident #5 out of disperation. She stated he required close observation at all times due to his repeated behavior to attempting to ambulate from his wheelchair. She stated the sheet should not have been placed around Resident #5 and tied to his wheelchair and the staff should have tried a different option but she felt there was no maliace in the action.

A telephone interview was conducted with the Adminstrator and DON on 10/23/20 at 2:00 PM. The Adminstirator stated they immediately started the investigation and gathered interviews when they became aware of the incident involving Resident #5. He stated there was never any concrete evidence as to who did it but he suspended the Nurse #1 and NA #2 pending the outcome of the investigation. He stated nobody would confess and there were conflicts in the staff statements. The Adminstrator stated he did not substantiate the abuse allegation and concluded there were a lot of over-whelmed staff who had been through a recent COVID-19 outbreak. He stated he in no way felt anyone tied Resident #5 into his wheelchair to be malisious but rather as a desprite attempt to keep him from repeadily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 16	F 604		

attempting to get out of wheelchair and attempting to ambulate. The Administrator and DON stated it was their expectation that other interventions be attempted with Resident #5 and it was never the facility's expectation that staff utilized a physical restraint such as a sheet to prevent Resident #5 from falling.

2. Resident #4 was admitted on 4/4/17 with a diagnosis of Cerebral Vascular Accident (CVA).

Resident #4's medical record revealed a consent for a pommel cushion with the indication of positioning. The consent was dated 5/27/20.

Resident #4's care plan dated 5/27/20 read she used a physical restraint of the pommel cushion. Interventions included a valid consent prior to initiating a restraint and ongoing evaluation of Resident #4's restraint for continued use, risk versus benefits and alternatives to her restraint.

Review of Resident #4's most recent Physical Therapy and Plan of Treatment dated 7/30/20 read Resident #4 was referred by nursing due to a decrease in her functional mobility and strength. The evaluation did not include any documentation regarding the use of her pommel cushion.

Review of a Therapy Referral Form dated 8/13/20 read Resident #4 required the continued use pommel the cushion but did not include any documentation regarding the reason of the continued use of the pommel cushion.

Review of Resident #4's Physician orders included an order dated 8/13/20 for a pommel cushion for positioning and to facilitate an upright posture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 17	F 604		

Resident #4's 5-day Minimum Data Set (MDS) dated 9/16/20 did not include any indication of the use of a restraint.

Review of Resident #4's electronic medical record (EMR) from 1/1/20 to present did not include any evidence of a restraint reassessment or an attempt for a lesser restrictive device being attempted for the pommel cushion being utilized.

An observation and staff interview were conducted on 10/22/20 at 9:15 AM. Resident #4 was still in bed. In her wheelchair was a pommel cushion. Nursing Assistant (NA) #5 stated Resident #4 had the pommel as long as she could remember and Resident #4 was unable to remove the pommel cushion when she was seated in her wheelchair. NA #5 stated to her knowledge, the pommel cushion was for positioning and did not restrict her movement or access to her body. She stated was not aware of any recent falls.

An interview was conducted with Unit Manager (UM) #1 on 10/22/20 at 9:20 AM. She stated the facility completed 2 restraint reduction attempts with the last one being 5/27/20. She stated she was unable to provide any documentation regarding the failed restraint reduction attempts. UM #1 stated the process for the restraint reassessment was as follows: The MDS Nurse gave her and the other UM a list of upcoming MDS assessments and then she assigned all the reassessments to the 3rd shift floor nurses. She stated it was the expectation that a restraint reassessment be completed quarterly with an attempted restraint reduction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 18	F 604		

An interview was conducted with the Rehabilitation Manager (RM) on 10/22/20 at 10:30 AM. She confirmed she had no documented evidence of a restraint reduction attempt but stated the continued need for the pommel cushion was documeted on a Therapy Referral Form dated 8/13/20 that was completed on Resident #4's readmission on 7/29/20. She stated the facility changed in owership October 2019 and she lost the previous documentation on Resident #4. The RM stated the resident's were discussed in the morning stand up meetings and there was no referral made to therapy to reassess for the continued need of Resident #4's pommel cushion.

An interview was conducted with the MDS Nurse on 10/22/20 at 10:38 AM. She stated it was up to the 3rd shift nurses to do all the quarterly assessments to include the restraint assessment. She stated she gave the UM's a list 3 months in advance and the UM's gave the list to the 3rd shift nurses to completed the assessments. The MDS Nurse stated she verified the assessments were completed when she completed the MDS and it was her understanding that the UM's audited the assessments for completion as well. The MDS Nurse stated she was ultimately responsible to ensure the restraint assessments were completed and restraint reduction reminders were communicated to the UM's and RM. The MDS Nurse stated she did not think Resident #4 could physically removed the pommel cushion from her wheelchair and the cushion was needed for positioning. She stated the pommel cushion did not restrict Resident #4's movement because she was unable to self propel the wheelchair. The MDS Nurse stated she did not think the pommel cushion restricted Resident #4 from access to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 19	F 604		

body.

An telephone interview was conducted on 10/23/20 at 2:00 PM with the Adminsitrator and the Director of Nursing. Both stated it was their expectation that a restraint reassessment and a restraint reduction attempt be completed quarterly to ensure Resident #4 was provided with the least restrictive device and for positioning.

3. Resident #6 was admitted on 1/14/17 with a diagnosis of Dementia.

Review of Resident #6's physical restraint care plan dated last revised on 10/16/19 read she required the use of a pommel cushion while up in her wheelchair for positioning. There was only one intervention still active and the other interventions were resolved. The intervention read to ensure Resident #6 was positioned correctly with proper body alignment.

Review of Resident #6's most recent Physical Therapy Evaluation and Plan of Treatment dated 7/16/20 read Resident #6 was referred by nursing due to a decrease in her functional mobility and strength. The evaluation read Resident #6 had no falls in the past year and the only mention of the pommel cushion was listed as prior equipment used prior to onset of change in functional ability.

Resident #6's quarterly Minimum Data Set dated 7/22/20 did not include any indication of the use of a restraint.

Review of Resident #6's medical record did not include any orders for a pommel cushion until 10/22/20 when the facility obtained verbal consent from Resident #6's Responsible Party

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 20	F 604		

(RP).

Review of Resident #6's electronic medical record (EMR) from 1/1/20 to present did not include any evidence of a restraint reassessment or an attempt for a lesser restrictive device being attempted for the pommel cushion being utilized.

An interview was conducted with Unit Manager (UM) #1 on 10/22/20 at 9:15 AM. She stated she was unable to provide any documentation regarding a failed restraint reduction attempt. UM #1 stated the process for the restraint reassessment was as follows: The MDS Nurse gave her and the other UM a list of upcoming MDS assessments and then she assigned all the reassessments to the 3rd shift floor nurses. She stated it was the expectation that a restraint reassessment be completed quarterly with an attempted restraint reduction.

An observation and staff interview were conducted on 10/22/20 at 9:30 AM. Resident #6 was still in bed. In her wheelchair was a pommel cushion. Nursing Assistant (NA) #4 stated Resident #6 had the pommel cushion for a long time and used it daily when seated in her wheelchair. She stated was not aware of any recent falls. NA #4 stated to her knowledge, the pommel cushion was for positioning and did not restrict her movement or access to her body. She stated was not aware of any recent falls.

An interview was conducted with the Rehabilitation Manager (RM) on 10/22/20 at 10:30 AM. She stated she was unable to find any evidence of a restraint reassessment or screening for Resident #6 pommel cushion. She stated the facility changed in owership October

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 21	F 604		

2019 and she lost the previous documentation on Resident #6. She confirmed she had no documented evidence of a restraint reduction attempt for Resident #6. The RM stated the residents were discussed in the morning stand up meetings and there was no referral made to therapy to reassess for the continued need for Resident #6's pommel cushion.

An interview was conducted with the MDS Nurse on 10/22/20 at 10:38 AM. She stated it was up to the 3rd shift nurses to do all the quarterly assessments to include the restraint assessment. She stated she gave the UM's a list 3 months in advance and the UM's gave the list to the 3rd shift nurses to completed the assessments. The MDS Nurse stated she verified the assessments were completed when she completed the MDS and it was her understanding that the UM's audited the assessments for completion as well. The MDS Nurse stated she was ultimately responsible to ensure the restraint assessments were completed and restriant reduction reminders were communicated to the UM's and RM. The MDS Nurse stated she did not think Resident #6 could physically removed the pommel cushion from her wheelcahir and the cushion was needed for positioning. She stated the pommel cushion did not restrict Resident #4's movement because she was unable to self propel the wheelchair. The MDS Nurse stated she did not think the pommel cushion restricted Resident #4 from access to her body.

An telephone interview was conducted on 10/23/20 at 2:00 PM with the Adminsitrator and the Director of Nursing. Both stated it was their expectation that a restraint reassessment and a restraint reduction attempt be completed quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 22 to ensure Resident #6 was provided with the least restrictive device and for positioning.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of restraints (Resident #4 and Resident #6) and nutrition (Resident #3). This was for 3 of 9 residents reviewed for MDS accuracy. The finding included: 1. Resident #4 was admitted on 4/4/17 with a diagnosis of Cerebral Vascular Accident (CVA). Resident #4's medical record revealed a consent for a pommel cushion with the indication of positioning. The consent was dated 5/27/20. Resident #4's care plan dated 5/27/20 read she used a physical restraint of the pommel cushion. Review of a Therapy Referral Form dated 8/13/20 read she required the continued use pommel cushion. The referral form did not have any documentation regarding the rationale for the need of the pommel cushion. Review of Resident #4's Physician orders included an order dated 8/13/20 for a pommel cushion for positioning and to facilitate an upright posture.	F 641	F-641 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 11/06/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the MDS staff to accurately code restraints and (nutrition) weight loss.	11/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23 Resident #4's 5-day Minimum Data Set (MDS) dated 9/16/20 did not include any indication of the use of a restraint. An observation and staff interview were conducted on 10/22/20 at 9:15 AM. Resident #4 was still in bed. In her wheelchair was a pommel cushion. Nursing Assistant (NA) #5 stated Resident #4 had the pommel as long as she could remember and Resident #4 was unable to remove the pommel cushion from her wheelchair. NA #5 stated to her knowledge, the pommel cushion was for positioning and did not restrict her movement or access to her body. She stated was not aware of any recent falls. An interview was conducted on 10/22/20 at 10:38 AM with the MDS Nurse. She confirmed she completed section P (restraints) of the MDS dated 9/16/20. She stated the of a pommel should have been coded for when Resident #4 was up in a chair. The MDS Nurse stated she did not think Resident #4 could physically removed the pommel cushion from her wheelcahir and the cushion was needed for positioning. She stated the pommel cushion did not restrict Resident #4's movement because she was unable to self propel the wheelchair. The MDS Nurse stated she did not think the pommel cushion restricted Resident #4 from access to her body. An telephone interview was conducted on 10/23/20 at 2:00 PM with the Adminsitrator and the Director of Nursing. Both stated Resident #4's MDS should have been coded accurately in the area of restraints. 2. Resident #6 was admitted on 1/14/17 with a	F 641	For affected resident(s): Resident #4s MDS for restraint use was corrected on 10/27/2020. Resident #6s MDS for restraint use was corrected on 10/27/2020. Resident #3s MDS for weight loss was corrected on 11/6/2020. For other residents with the potential to be affected: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. A 100% audit was completed on 11/9/2020 by the MDS coordinator to ensure that all restraints and nutrition were accurately coded on the MDS. No other inaccuracies were identified. Facility plan to prevent re-occurrence: On 11/6/2020 the Administrator and the DON initiated re-education to the MDS staff regarding the need for accurate coding on the MDS to reflect the use of restraints and (nutrition) weight loss. Facility plan to monitor its performance to make sure that solutions are sustained: An audit sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents with a restraint and weight loss or any nutritional concerns are coded accurately on the MDS. This monitoring process will take place daily (M-F) for 3 weeks, weekly for 3 weeks, then monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24 diagnosis of Dementia. Review of Resident #6's physical restraint care plan dated last revised on 10/16/19 read she required the use of a pommel cushion while up in her wheelchair for positioning. Resident #6's quarterly Minimum Data Set dated 7/22/20 did not include any indication of the use of a restraint. Review of Resident #6's medical record did not include any orders for a pommel cushion until 10/22/20. An observation and staff interview was conducted on 10/22/20 at 9:30 AM. Resident #6 was still in bed. In her wheelchair was a pommel cushion. Nursing Assistant (NA) #4 stated Resident #6 had the pommel cushion for a long time. She stated was not aware of any recent falls. NA #4 stated to her knowledge, the pommel cushion was for positioning and did not restrict her movement or access to her body. She stated was not aware of any recent falls. An interview was conducted on 10/22/20 at 10:38 AM with the MDS Nurse. She confirmed she completed section P (restraints) of the MDS dated 7/22/20. She stated the use of a pommel should have been coded for when Resident #6 was up in a chair. The MDS Nurse stated she did not think Resident #6 could physically removed the pommel cushion from her wheelcahir and the cushion was needed for positioning. She stated the pommel cushion did not restrict Resident #6's movement because she was unable to self propel the wheelchair. The MDS Nurse stated she did not think the pommel cushion restricted Resident	F 641	The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/9/2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 25	F 641		

#4 from access to her body.

An telephone interview was conducted on 10/23/20 at 2:00 PM with the Adminsitrator and the Director of Nursing. Both stated Resident #6's MDS should have been coded accurately in the area of restraints.

3. Resident #3 was admitted on 9/4/20 with a stage 4 pressure ulcer to her sacrum.

Review of Resident #3's admission Minimum Data Set (MDS) dated 9/12/20 indicated a weight of 187 pounds. She was coded as being on a prescribed weight loss regime at section K (nutrition) of the MDS. Section K was completed by the Dietary Manager (DM).

Review of Resident #3's weight on 9/12/20 was 182.4 pounds.

Review of Resident #3's October 2020 orders included orders for a house supplement three times daily, fortified foods and 1:1 eating assistance with all meals.

An observation and staff interview was conducted on 10/20/20 at 12:20 PM. Nursing Assistant (NA) #6 was observed feeding Resident #6 her lunch. She stated Resident #6 was losing weight and was now required total staff assistance with eating. She stated Resident #6 was on a fortified diet with supplements.

An interview was conducted on 10/22/20 at 10:38 AM with the MDS Nurse. She stated the DM was responsible for coding section K of the MDS but she was responsible to ensure the MDS was accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 26 An interview was conducted on 10/22/20 at 10:57AM with the DM. He stated he was aware that Resident #3 had experienced a significant weight loss. He stated coding Resident #3's MDS dated 9/12/20 for a prescribed weight loss regime was a mistake. An telephone interview was conducted on 10/23/20 at 2:00 PM with the Adminsitrator and the Director of Nursing. Both stated Resident #3's MDS should have been coded accurately in the area of nutrition.	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and physicians, the facility failed to follow up with wound care referral (Resident #3) for 1 of 3 residents reviewed for pressure ulcers. Findings included:	F 686	F-686 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an	11/9/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 1.Resident #3 was admitted to the facility on 9/4/2020 with diagnoses that included intellectual disability, diabetes type 2, and stage 4 pressure ulcer of the sacrum. The resident's admission Minimum Data Set (MDS), dated, 9/12/2020, indicated the resident was severely cognitively impaired, and required extensive assistance with all activities of daily living and personal hygiene. Resident #3 was coded as having a stage 4 pressure ulcer during the assessment period. Physician #3's provider note, written 9/10/2020, revealed the resident had a stage 4 pressure ulcer on the sacrum and requested a referral to wound care physician. Review of Resident #3's medical records on 10/20/2020 did not indicate Resident #3 had ever been seen or treated by a wound care physician and did not reveal an order for wound care physician consult. On 10/23/2020 at 8:05am a phone interview was conducted with physician #3. He stated he was familiar with Resident #3 and aware of her stage 4 pressure ulcer on her sacrum. He further stated he saw the resident via telehealth in September and referred her to the wound care physician but did not know if the consult was completed. He stated he is currently seeing residents via telehealth and typically dictates his history and physicals and sends those to the facility electronically. A phone interview was conducted with Physician #4, wound care physician, on 10/23/2020 at	F 686	admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 11/06/2020 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequate training/understanding of the nursing staff on the process of following up on a wound care referral to the wound care physician (Vohra). For affected resident(s): Resident #3 no longer resides in the facility. For other residents with the potential to be affected: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. A 100% audit was completed on 11/9/2020 by the Director of Nursing to ensure that there were no other referrals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 11:31am. She stated she does provide wound care for residents in the facility but she has not received a referral for Resident #3. She stated she was providing services face to face and via telehealth during the month of September and throughout the COVID outbreak. On 10/23/2020 at 8:13am an interview was conducted with the Director of Nursing (DON) regarding the referral to wound care. She stated Physician #3 would typically dictate the provider note or history and physical and send it to her or write and order and send it with his file the next day. She was not certain why the referral was not made. An interview was conducted with the DON and the facility administrator on 10/23/2020 at 2:00pm. Both the DON and the administrator stated it was their expectation referrals to wound care physicians be completed when requested by facility's physician.	F 686	that were missed to the wound care Dr. (Vohra). No newly discovered missed referrals were identified. Facility plan to prevent re-occurrence: On 11/06/2020 the DON initiated re-education to the nursing staff regarding the process on how to handle referrals that are made to the wound care physician by the facility and/or a facility physician. Facility plan to monitor its performance to make sure that solutions are sustained: An audit sheet will be done by the Administrator, DON, or designee to monitor and ensure that all referrals to the wound care physician (Vohra) are properly executed. This monitoring process will take place daily (M-F) for 3 weeks, weekly for 3 weeks, then monthly for 3 months. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/9/2020.	