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 _____	05/04/2023

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 05/01/23 through 05/04/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# NEJG11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on 05/01/23 through 05/04/23. Event ID# NEJG11.	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.	F 550		6/1/23

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

Electronically Signed | 05/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	05/04/2023

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 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. §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, record reviews, and staff interviews, the facility failed to provide a dignified dining experience by referring to a resident who needed assistance with meals as a "feeder" (Resident #59) .This was for 1 of 2 residents reviewed for dignity. Based on the reasonable person concept residents would not expect to be identified as a "feeder". The findings included: Resident #59 was admitted to the facility on 07/01/20. The quarterly Minimum Data Set dated 01/17/23 indicated Resident #59's cognition was severely impaired. Resident #59 required total assistance with eating. During an observation on 05/01/23 at 11:57 AM, Nurse Aide #5 was observed in the dining room of the memory care unit assisting with meal pass.	F 550	Resident #59 was not affected by the deficient practice. The Director of Nursing educated nurse aide # 5 on 1:1 on the resident rights, dignity and how to address a resident that required assistance with meals on 5-1-23. All residents that require assistance with meals have the potential to be affected by the deficient practice. The Director of Nursing completed a facility wide audit on current residents that are assisted or dependent on staff for meals on 5-8-23 and revised audit with new residents add on 5-20-23. No other resident was affected by the deficient practice. The Director of Nursing educated the nursing staffing on Respect and Dignity of Residents. All Nursing Staff were educated that residents were not to be addressed as “ feeders” but as an assistant with meals by 5-5-23, this includes all shifts and weekends . New	

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 _____	05/04/2023

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 When asked by another staff member if Resident #59 needed assistance with eating, she stated "she's a feeder." The statement could be heard throughout the entire dining room where other residents were present. During an interview on 05/01/23 at 11:59 AM Nurse Aide #5 stated she identified Resident #59 as a "feeder" because she did not know what else to call a resident who needed assistance with meals. She thought it was a dignified label and used that term to identify residents who needed assistance with meals. An interview with the Director of Nursing (DON) on 05/04/34 at 11:44 AM revealed it was her expectation that staff should not utilize labels such as "feeder" to describe a resident and staff had been educated about not using "feeder" to identify residents who need assistance with meals.	F 550	hires will be educated on respect and dignity of residents and not to be addressed as “feeders.” Any nursing staff that has not received education will not be able to work until doing so. The Unit Managers and /or designee will complete meals observations 5 days per week times 4 weeks, and then monthly times 3 months to ensure that residents are treated with dignity, respect, and not labeled/addressed as feeders. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews, the facility failed to place a resident's call light (Resident #15 and #79) within reach to allow for the residents to request staff assistance for 2 of 3 residents reviewed for accommodation of needs.	F 558	Resident #15 and Resident #79 had no adverse effects from the deficient practice. Observed call lights within reach of resident #15 and resident #79 by licensed nurse on 5-5-23.	6/1/23

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 _____	05/04/2023

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 558	Continued From page 3 The findings included: 1. Resident #15 was admitted to the facility on 10/31/14 with diagnoses that included cerebrovascular accident (CVA) with left sided hemiplegia (paralysis on one side of the body). The quarterly Minimum Data Set (MDS) assessment dated 02/07/23 indicated Resident #15's cognition was fully intact. He had no behaviors and no rejection of care. He required the extensive assistance of 1 for bed mobility and supervision with set up help for eating. He had no functional limitations with range of motion on one side of his upper and lower extremities. Resident #15's active care plan indicated he has had falls related to limitations that included, in part, left sided hemiplegia. The interventions included ensuring his call light was within reach and encouraging the resident to use it for assistance as needed. An observed was conducted on 05/01/23 at 01:28 of Resident #15. He was observed asleep lying on his bed. His call light was on the floor under the left side of his bed. An observed was conducted on 05/02/23 at 08:50 AM of Resident #15. He was observed asleep lying on his bed. His call light was on the floor under the left side of his bed. An observation and interview were conducted on 05/03/23 at 10:01 AM with Nurse #1. He verified Resident #15 ' s call light was on the floor under his bed. He stated the call light should be within the residents reach at all times. He was observed	F 558	The Director of Nursing educated nurse # 1 and nurse assistant #1 on 1:1 of residents' call lights within reach to allow for the residents to request staff assistance on 5-5-23. All residents have the potential to be affected by the deficient practice. The Director of Nursing completed a facility wide audit on call lights within reach of all residents on 5-8-23 and a revised audit to include new residents on 5-20-23. No issues identified. The Director of Nursing educated staff to ensure that call lights are within reach of residents to allow the residents to request staff assistance on 5-5-23, this includes all shifts and weekends. Any staff that has not received education will not be able to work until doing so. New hires will be educated on call lights within reach of residents to allow the residents to request staff assistance. The Unit Managers and /or designee will complete a call light audit on residents for reasonable accommodations needs and preferences 5 residents per day times 5 days per week times 4 weeks, and then monthly times 3 months to ensure that call lights are within reach per resident's reasonable accommodation needs and preferences. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly	

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 _____	05/04/2023

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 558	Continued From page 4 putting the call light within residents reach. An observation and interview were conducted on 05/03/23 at 11:48 AM with Resident #15. He was lying in bed watching television. He stated the call light was on the floor all the time. He also stated when he needs something and/or when he needs assistance, he stated he will get up and try to get the call light so he can ring it, yell out for someone, or get up by himself. Resident #15 observed pulling self-up to the side of the bed using his right arm and the grab bar. He was not able to use his left side. He further stated sometimes he did fall when he attempted to get up unassisted. An interview was conducted on 05/03/23 at 12:10 PM with the Nurse Assistant (NA) #1, who was assigned to Resident #15 for the 7:00 AM to 3:00 PM shift, she revealed she was unaware the call light cord was not within reach. She indicated the resident didn ' t use his call light to request assistance very much, but it should still be within his reach. NA #1 indicated she normally places the call light within Resident #15's reach before leaving his room. An observation and interview were conducted on 05/03/23 at 2:47 PM with Nurse #1. He stated Resident #15 will throw his call light onto the floor after staff put it in reach. He further stated staff are used to Resident #15 doing everything for himself, he doesn ' t normally use his call light for assistance, and they forget to put the call light within reach. He then stated his call light should be within reach at all times. Review of nursing notes from January to present revealed no documentation of Resident #15 not	F 558	for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 558	Continued From page 5	F 558		

using his call light or throwing the call light on the floor.

An interview was conducted on 05/04/23 at 11:00 AM the Director of Nursing (DON), she stated the call light device should always be in the residents reach.

2. Resident #79 was admitted to the facility on 11/08/22 with diagnosis that included diabetes, diabetic neuropathy, anxiety, and dysphagia.

The quarterly Minimum Data Set (MDS) assessment dated 02/14/23 indicated Resident #79's cognition was fully intact. He had no behaviors and no rejection of care. He required the extensive assistance of 1 for bed mobility and supervision with oversight, encouragement and/or cueing and set up help for eating. He had no functional limitations with range of motion.

Resident #79's active care plan indicated was at high risk for falls fall and had a history of falls related to antipsychotic medications, debility, poor balance and unsteady gait. Interventions included for staff to be sure resident's call light was within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance.

An observation was conducted with Resident #79 on 05/02/23 at 8:48 AM. He was observed in his room in bed with his bedside table pulled over the left side of the bed. His call light was observed clipped to the bedsheet on the right side of his bed with the push button hanging off bed out of Resident #79 ' s reach.

An observation and interview were conducted 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 _____	05/04/2023

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 558	Continued From page 6 05/03/23 at 10:01 AM with Nurse #1. He verified Resident #79 ' s call light was on the floor. He stated the call bell was attached to the bed but had fallen off the bed and the call bell should be within the residents reach at all times. He was observed putting the call light within residents reach. An observation and interview were conducted on 05/03/23 at 11:45 AM with Resident #79. He was lying in bed watching television. He stated his call light was on the floor a lot. Resident #79 stated, "I like to have it pinned where I can reach it". He further stated if he needed anything and can't reach it, he would yell out for someone to come to the room. An interview was conducted on 05/03/23 at 12:10 PM with the Nurse Assistant (NA) #1, who was assigned to Resident #79 for the 7:00 AM to 3:00 PM shift, she revealed she was unaware the call light was not within reach. She indicated the resident utilized his call light to request assistance. She stated it was clipped onto the sheet but must have fallen off the bed. NA #1 indicated she normally places the call light within Resident #79's reach before leaving his room. An interview was conducted on 05/04/23 at 11:00 AM the Director of Nursing (DON), she stated the call light device should always be in the residents reach.	F 558		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		6/1/23

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 _____	05/04/2023

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 623	Continued From page 7	F 623		

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written

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 _____	05/04/2023

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 623	Continued From page 8	F 623		

notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information

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 _____	05/04/2023

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 623	Continued From page 9 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party interview, and staff interviews, the facility failed to notify the resident and/or the responsible party (RP) in writing of the reason for the transfer/discharge to the hospital for 2 of 2 sampled residents reviewed for hospitalizations (Residents #14 and #10). Findings included: 1. Resident #14 was originally admitted to the facility on 10/31/22 and readmitted back to the facility on 05/04/23 with diagnoses which included chronic obstructive pulmonary disease. Resident #14's quarterly Minimum Data Set (MDS) assessment dated 03/09/23 indicated she was cognitively intact. The nurse's note by Nurse #2 dated 04/28/23 at 9:49 PM indicated Resident #14 was sent to the Emergency Room due to critical lab results and a fever. Review of the Nursing Home Notice of	F 623	Resident #14 and Resident #10's written discharge/transfer notification were sent to the responsible parties/Ombudsman by Social Service Director on 5-24-23. All residents discharged to the hospital have the potential to be affected by the deficient practice. Social Service Director completed a 30-day look back audit on all residents discharged and transferred from the facility to ensure that the facility was following its policy on the written reason of transfer and discharge to resident and/or responsible party and Ombudsman on 5-8-23 and 5-24-23. The Administrator educated Social Service Director 1:1 on policy and procedures for sending written notification to resident and/or responsible party when transfer/discharge occurs initiated by the facility on 5-11-23. All new social services hires will be educated on written transfer/discharge notification policy on residents transferred/discharged.	

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 _____	05/04/2023

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 623	Continued From page 10 Transfer/Discharge form dated 05/01/23 indicated the reason for transfer was "it is necessary for your welfare and your needs cannot be met in this facility." This document was kept in a binder. Review of progress notes in Resident #14's medical record did not indicate the Nursing Home Notice of Transfer/Discharge was given to the resident or her RP. Resident #14's Responsible Party (RP) was interviewed on 05/03/23 at 9:36 AM. He stated he received a phone call each time Resident #14 was transferred to the hospital but had never received anything in writing. The RP stated he was not notified in writing of the transfer on 4/28/23. The Social Services Director was interviewed on 05/02/23 at 3:06 PM. The Social Services Director stated nurses were responsible for providing written notification of the transfer. An additional interview with the Social Services Director occurred on 05/03/23 at 3:35 PM. She stated the Administrator had been filling out the Nursing Home Notice of Transfer/Discharge form but she did not know it needed to be sent to a resident's Responsible Party. She stated the completed Nursing Home Notice of Transfer/Discharge forms is kept in a binder in her office. A joint interview with the Administrator and Director of Nursing (DON) occurred on 05/04/23 at 11:38 AM. The DON stated the Nursing Home Notice of Transfer/Discharge form should have been mailed out and it is the responsibility of the Social Services Director to ensure the form is	F 623	Social Services Director will complete audits 5 days per week times 4 weeks, and then monthly times 3 months on facility initiated written transfer/discharge notification sent to resident and/or responsible party and Ombudsman. The Social Service Director or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 623	Continued From page 11	F 623		

mailed to a resident's RP. The Administrator indicated it is her expectation for the Social Services Director to send the Nursing Home Notice of Transfer/Discharge form to be sent to a resident's RP when the resident is transferred to the hospital.

2. Resident #10 was originally admitted on 7/22/13 and readmitted on 4/3/23 with cumulative diagnoses of Diabetes, anxiety and depression.

Resident #10's quarterly Minimum Data Set dated 3/8/23 indicated he was cognitively intact.

Review of a nursing note dated 3/30/23 read Resident #10 was complaining of not being able to stand independently and unable to get out of his bed due to severe tremors. He was transferred to the hospital for an evaluation.

An interview was completed on 5/1/23 at 1:24 PM with Resident #10. He recalled being sent to the hospital on 3/30/23 and stated he did not recall the facility providing him or his Responsible Party (RP) anything in writing regarding the reason for his hospital transfer.

An interview was completed on 5/3/23 at 3:30 PM with Nurse #2. She stated when a resident was sent out to the hospital, she only had the resident sign the bed hold policy. Nurse #2 stated she was not aware that a written reason for a hospital transfer was needed.

An interview was completed on 5/3/23 at 3:35 PM

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 _____	05/04/2023

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 623	Continued From page 12 with the Social Services Director. She stated she thought the Administrator had been filling out the hospital transfer forms but she was not aware a written reason for a resident's hospital transfer. A telephone message was left on 5/3/23 at 3:20 PM for Resident #10's RP with no return call as of survey exit of 5/4/23.	F 623		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit	F 640		6/1/23

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 _____	05/04/2023

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 640	Continued From page 13 encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit to the Centers for Medicare and Medicaid Services (CMS) database quarterly Minimum Data Set (MDS) assessment within the required time frame for 4 of 8 residents selected to be reviewed for submission of Resident Assessments (Residents #10, #17, #77, and #79). The findings included: 1. Resident #10 was admitted to the facility on 7/22/2013. a. Resident#10 had a discharge MDS assessment dated 3/30/2023. There was no indication the assessment had been transmitted.	F 640	Resident 10, 17,77, and 79 suffered no adverse effects from the alleged deficient practice. Resident 10, 17, 77 and 79□s Minimum Data Set (MDS) assessments were submitted to Centers for Medicare and Medicaid on 5/2/23 by Regional Minimum Data Set (MDS) Consultant. All residents with quarterly minimum data set assessments due within 7 days of completion of assessments have the potential to be affected by this deficient practice. Regional MDS Coordinator completed an audit to ensure all assessments that were due had been submitted by 5-2-23. Education was completed by the Regional MDS Consultant with the MDS	

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 _____	05/04/2023

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 640	Continued From page 14 b. Resident #10's most recently completed MDS was dated 4/3/2023 and was coded as an entry tracker. On 5/1/2023 a phone interview was conducted with the Regional MDS Coordinator. She stated she had been helping the facility's MDS nurse who is part time. She further stated the facility's MDS nurse was responsible for transmitting all of the MDS assessments when they were ready to export. She believed MDS assessments did not get transmitted due to error or oversite. On 5/04/2023 at 10:03 AM a phone interview was conducted with the facility's part time MDS nurse. She stated she has been working with the facility part time since July 2022 and is only in the facility on Sundays. She had recently been asked to start transmitting MDS assessments due to difficulty keeping a full time MDS nurse. She further stated she did not have the access required to transmit MDS at that time. The MDS nurse stated the Regional MDS Coordinator had been transmitting the assessments in the absence of a full time MDS nurse. The facility's MDS nurse was told her access information was emailed to her but recently found out the information was emailed to the wrong email address, and she never received it. She further stated she still did not have access. The Corporate MDS Coordinator transmitted the overdue assessments. An interview was conducted on 05/04/2023 at 11:13 AM with the Administrator and the Director of Nursing (DON). The Administrator stated the late MDS assessments had been transmitted by the Regional MDS coordinator. She believed the failure to transmit the assessments within the	F 640	Coordinator on the timely transmission of MDS 5-5-23. A second as needed coordinator will be given access to submit to provide a back up person to the facility. The facility will audit assessments weekly in Point Click Care by MDS coordinator to ensure no assessments wait longer than 7 days for submission after completion of the assessment. The regional MDS coordinator will audit the assessments weekly times four weeks and then monthly times three months to ensure timely submissions of assessments. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of compliance: June 1, 2023	

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 _____	05/04/2023

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 640	Continued From page 15	F 640		

required 14-day time frame was an oversight.

2. Resident #17 was admitted to the facility on 9/14/2022.

A review of Resident #17's most recently completed MDS was dated 4/7/2023 and was coded as a quarterly assessment. There was no indication the assessment had been transmitted.

On 5/1/2023 a phone interview was conducted with the Regional MDS Coordinator. She stated she had been helping the facility's MDS nurse who is part time. She further stated the facility's MDS nurse was responsible for transmitting all of the MDS assessments when they were ready to export. She believed MDS assessments did not get transmitted due to error or oversite.

On 5/04/2023 at 10:03 AM a phone interview was conducted with the facility's part time MDS nurse. She stated she has been working with the facility part time since July 2022 and is only in the facility on Sundays. She had recently been asked to start transmitting MDS assessments due to difficulty keeping a full time MDS nurse. She further stated she did not have the access required to transmit MDS at that time. The MDS nurse stated the Regional MDS Coordinator had been transmitting the assessments in the absence of a full time MDS nurse. The facility's MDS nurse was told her access information was emailed to her but recently found out the information was emailed to the wrong email address, and she never received it. She further stated she still did not have access. The Corporate MDS Coordinator transmitted the overdue assessments.

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 _____	05/04/2023

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 640	Continued From page 16	F 640		

An interview was conducted on 05/04/2023 at 11:13 AM with the Administrator and the Director of Nursing (DON). The Administrator stated the late MDS assessments had been transmitted by the Regional MDS coordinator. She believed the failure to transmit the assessments within the required 14-day time frame was an oversight.

3. Resident #77 was admitted to the facility on 11/25/2022.

A review of Resident #77's most recently completed MDS was dated 3/31/2023 and was coded as a quarterly assessment. There was no indication the assessment had been transmitted.

On 5/1/2023 a phone interview was conducted with the Regional MDS Coordinator. She stated she had been helping the facility's MDS nurse who is part time. She further stated the facility's MDS nurse was responsible for transmitting all of the MDS assessments when they were ready to export. She believed MDS assessments did not get transmitted due to error or oversite.

On 5/04/2023 at 10:03 AM a phone interview was conducted with the facility's part time MDS nurse. She stated she has been working with the facility part time since July 2022 and is only in the facility on Sundays. She had recently been asked to start transmitting MDS assessments due to difficulty keeping a full time MDS nurse. She further stated she did not have the access required to transmit MDS at that time. The MDS nurse stated the Regional MDS Coordinator had been transmitting the assessments in the absence of a full time MDS nurse. The facility's MDS nurse was told 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 _____	05/04/2023

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 640	Continued From page 17	F 640		

access information was emailed to her but recently found out the information was emailed to the wrong email address, and she never received it. She further stated she still did not have access. The Corporate MDS Coordinator transmitted the overdue assessments.

An interview was conducted on 05/04/2023 at 11:13 AM with the Administrator and the Director of Nursing (DON). The Administrator stated the late MDS assessments had been transmitted by the Regional MDS coordinator. She believed the failure to transmit the assessments within the required 14-day time frame was an oversight.

4. Resident #79 was admitted to the facility on 11/8/2022.

A review of Resident #79's most recently completed MDS was dated 3/17/2023 and was coded as a quarterly assessment. There was no indication the assessment had been transmitted.

On 5/1/2023 a phone interview was conducted with the Regional MDS Coordinator. She stated she had been helping the facility's MDS nurse who is part time. She further stated the facility's MDS nurse was responsible for transmitting all of the MDS assessments when they were ready to export. She believed MDS assessments did not get transmitted due to error or oversite.

On 5/04/2023 at 10:03 AM a phone interview was conducted with the facility's part time MDS nurse. She stated she has been working with the facility part time since July 2022 and is only in the facility on Sundays. She had recently been asked to start transmitting MDS assessments due to difficulty

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 _____	05/04/2023

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 640	Continued From page 18 keeping a full time MDS nurse. She further stated she did not have the access required to transmit MDS at that time. The MDS nurse stated the Regional MDS Coordinator had been transmitting the assessments in the absence of a full time MDS nurse. The facility's MDS nurse was told her access information was emailed to her but recently found out the information was emailed to the wrong email address, and she never received it. She further stated she still did not have access. The Corporate MDS Coordinator transmitted the overdue assessments. An interview was conducted on 05/04/2023 at 11:13 AM with the Administrator and the Director of Nursing (DON). The Administrator stated the late MDS assessments had been transmitted by the Regional MDS coordinator. She believed the failure to transmit the assessments within the required 14-day time frame was an oversight.	F 640		
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 staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of behaviors for Resident #59 and continence for Resident #5. This was for 2 of 17 residents reviewed for MDS accuracy. The findings included:	F 641	Resident #59 and #5 suffered no adverse effects from the alleged deficient practice. Resident #59 Minimum Data Set (MDS) assessment dated 1/17/23 was modified to accurately reflect documented behavior. Resident #5 MDS assessment dated 3/3/23 was modified to accurately reflect not rated for urinary incontinence. All residents with behaviors and foley	6/1/23

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 _____	05/04/2023

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 19 1. Resident #59 was admitted to the facility on 07/01/2020 with diagnoses which included early onset Alzheimer's disease and generalized anxiety disorder. Resident #59 medical record also had a progress note dated 01/11/23 by Nurse #5 which indicated she had episodes of rocking back and forth and yelling. The resident's significant change Minimum Data Set (MDS) assessment dated 01/17/2023 indicated the resident was severely cognitively impaired and no behavioral symptoms were exhibited. The Former Social Services Director was interviewed on 05/03/23 at 9:45 AM. She stated she completed the behavior assessment by sitting down with Resident #59 and watching her behavior. She stated on the day she sat down with Resident #59 she was not experiencing any behaviors. She stated she did not know she needed to look through a resident's medical chart to determine if a resident was experiencing behaviors during the assessment period. She further stated it was a mistake when she identified Resident #59's current behavior status, care rejection, or wandering as worse. The Director of Nursing was interviewed on 05/04/23 at 9:45 AM. She stated staff needed more education how to complete the behavior section of the MDS assessment. 2. Resident #5 was admitted to the facility on 06/16/10 with diagnosis that included cerebrovascular accident (CVA) with left sided	F 641	catheters have the potential to be affected by this deficient practice. An audit was completed for current residents with foley catheters and residents with behaviors within 7 days of Assessment reference Date(ARD) to ensure the urinary incontinence was coded accurately on the MDS and the behaviors were coded accurately on the MDS by Director of Nursing by 5-22-23. The Regional MDS Coordinator educated the MDS coordinator and Social Worker on accurate foley catheter coding and accurate behavior coding on assessments on 5-5-23. Any staff member not educated will not be able to work next shift until education is completed. The Regional MDS consultant or designee will complete audits 5 times a week times four weeks and then monthly times three months to ensure accurate coding for behaviors and foley catheters on assessments. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of compliance: June 1, 2023	

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 _____	05/04/2023

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 20 hemiplegia (paralysis on one side of the body). She also had an indwelling urinary catheter in place for neurogenic bladder. A physician's order dated 01/18/23 indicated Resident #5 to have a urinary catheter for neurogenic bladder. The quarterly Minimum Data Set (MDS) assessment dated 03/03/23 indicated Resident #5's cognition was severely impaired. Resident #5 was coded as having an indwelling urinary catheter and was also coded as always incontinent of bladder. Resident #5's active care plan, last reviewed on 03/22/23, included a focus area having an indwelling urinary catheter for neurogenic bladder. A phone interview was conducted on 05/04/23 at 9:36 AM with the Minimum Data Set (MDS) Nurse. She stated Resident #5 had an indwelling urinary catheter and it was an error to have coded her with bladder incontinence. This area should have been coded as "Not Rated". An interview was conducted on 05/04/23 at 11:00 AM with the Director of Nursing (DON). She stated the Minimum Data Set (MDS) assessment should have been coded to reflect Resident #5 ' s urinary continence accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		6/1/23

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 _____	05/04/2023

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 644	Continued From page 21 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to request residents with a newly diagnosed mental illness be reevaluated for a level II Preadmission Screening and Resident Review (PASRR) for 2 of 2 residents reviewed for PASRR (Resident #57 and #59). The findings included: 1. Resident #57 was admitted to the facility on 09/30/19 with diagnoses which included, in part, other frontotemporal neurocognitive disorder. Review of Resident #57's current PASRR determination letter dated 10/02/19 revealed the resident remained a level I and determined no further screening was required unless a significant changed occurred to suggest a diagnosis of mental illness. Resident #57's annual Minimum Data Set	F 644	Resident # 57 and Resident #59 had evaluation completed for PASRR ll screening on 5-24-23 for resident #57 and 5-26-23 for resident #59. All residents with newly diagnosis of mental illness have the potential to affected by the deficient practice. The Director of Nursing conducted an audit on all current residents with mental illness diagnoses to have a PASRR ll screening evaluation completed by 5/20/23. Administrator educated the Social Services Director and Director of Nursing to PASRR ll screening for residents with newly diagnosed mental illness on 5-4-23 . All new Social Service Directors will be educated on when PASRR ll evaluations	

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 _____	05/04/2023

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 644	Continued From page 22 Assessment (MDS) dated 09/08/22 indicated he was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. Review of Resident #57's medical record revealed a new diagnosis of schizoaffective disorder was documented on 01/24/22. The April and May 2023 Medication Administration Records were reviewed and included a physician order dated 03/23/23 for 0.5 milligrams of Haloperidol by mouth at bedtime related to schizoaffective disorder and was noted as administered daily. The Former Social Services Director was interviewed on 05/03/23 at 10:08 AM. She stated she thought Resident #57 was admitted into the facility with the diagnosis of schizoaffective disorder; therefore, did not contact the state for a PASRR reevaluation. She stated she was not notified Resident #57 had a new diagnosis of schizoaffective disorder. She would have requested a reevaluation for a level II PASRR. An interview was conducted on 05/03/23 at 9:19 AM with the Social Services Director. The Social Services Director stated she had only been in the role since February 2023 and was still learning. She stated if a resident was newly diagnosed with a mental disorder, she would notify the state for a reevaluation for a level II PASRR. She stated since Resident #57's schizoaffective disorder was diagnosed prior to her starting, she did not know why the PASRR II screening was not completed. During an interview on 05/04/23 at 11:40 AM, the Director of Nursing (DON) revealed the facility	F 644	need to be completed on all residents with newly diagnosis of mental illness. The Social Services Director will complete a PASRR level II check for newly mental illness diagnosis residents by audit of 5 residents 5 times a week times 4 weeks then monthly times 3 months to ensure PASRR II evaluations are completed. Social Service Director will attend clinical meetings 5 times weekly to ensure any new diagnosis of mental illness will have PASRR II evaluation to be completed if noted. The Social Service Director or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 644	Continued From page 23	F 644		

should have requested an evaluation for a new PASRR when Resident #57 was newly diagnosed with a mental disorder.

During an interview on 05/04/23 at 11:41 AM, the Administrator stated she expected a request for a PASRR evaluation when a resident was newly diagnosed with a mental disorder.

2. Resident #59 was admitted to the facility on 07/01/20 with diagnoses which included, in part, early onset Alzheimer's disease and cognitive communication deficit.

Review of Resident #59's current PASRR determination letter dated 11/12/19 revealed the resident remained a level I and determined no further screening was required unless a significant changed occurred to suggest a diagnosis of mental illness.

Review of Resident #59's medical record revealed a new diagnosis of schizoaffective disorder was documented on 07/27/22.

The April and May 2023 Medication Administration Records were reviewed and included a physician order dated 02/02/23 for 50 milligrams of Quetiapine tablet - give 1 tablet by mouth two times a day related to schizoaffective disorder and was noted as administered daily.

Resident #59's significant change Minimum Date Set (MDS) assessment dated 01/17/23 indicated she was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition.

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 _____	05/04/2023

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 644	Continued From page 24 The Former Social Services Director was interviewed on 05/03/23 at 10:08 AM. She stated she thought Resident #59 was admitted into the facility with the diagnoses of schizoaffective disorder; therefore, did not contact the state for a PASRR reevaluation. She stated she was not notified Resident #59 had a new diagnosis of schizoaffective disorder. She would have requested a reevaluation for a level II PASRR. An interview was conducted on 05/04/23 at 9:49 AM with the Social Services Director. The Social Services Director stated she had only been in the role since February 2023 and was still learning. She stated if a resident was newly diagnosed with a mental disorder, she would notify the state for a reevaluation for a level II PASRR. She stated since Resident #59's schizoaffective disorder was diagnosed prior to her starting, she did not know why the PASRR II screening was not completed. During an interview on 05/04/23 at 11:40 AM, the Director of Nursing (DON) revealed the facility should have requested an evaluation for a new PASRR when Resident #59 was newly diagnosed with a mental disorder. During an interview on 05/04/23 at 11:41 AM, the Administrator stated she expected a request for a PASRR evaluation when a resident was newly diagnosed with a mental disorder.	F 644		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		6/1/23

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 _____	05/04/2023

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 657	Continued From page 25 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise the care plans in the areas of pneumonia (Resident #79), infection (Resident #45), ambulation (Resident #3) and level 2 Pre-Admission Screening and Resident Review (PASRR) (Resident #57). This was for 4 of 17 residents reviewed for care plans. The findings included: 1. Resident #79 was admitted to the facility on 11/08/22 with diagnosis that included bacterial pneumonia.	F 657	Resident #79, 45, 57 and 3 suffered no adverse effects from the deficient practice. Resident #79□s pneumonia was resolved and was removed from the careplan on 5-18-23 by Minimum Data Set (MDS) coordinator, resident #45 infection was resolved and care plan updated for the removal of the infection on 5-5-23 by MDS coordinator, resident #57 level II care plan was updated and removed due to being level I with updates by MDS coordinator on 5-27-23, resident #3□s elopement care plan was updated and elopement removed on 5-5-23 by	

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 _____	05/04/2023

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 657	Continued From page 26 Resident #79's active care plan, last reviewed on 02/23/23, revealed a focus that read resident had Pneumonia. Date Initiated: 11/30/2022. A phone interview was conducted on 05/04/23 at 9:36 AM with the Minimum Data Set (MDS) Nurse. She stated it was an oversite that the focus for pneumonia on Resident #79 ' s care plan had not been updated and removed. 2. Resident #45 was admitted to the facility on 09/12/19 with diagnosis that included other specified disorders of bone density. He had a diagnosis of osteomyelitis on 05/05/22. Resident #45's active care plan, last reviewed on 02/13/23, revealed a focus that read resident had an infection (osteomyelitis). Date Initiated: 05/05/22. A phone interview was conducted on 05/04/23 at 9:36 AM with the Minimum Data Set (MDS) Nurse. She stated it was an oversite that the focus for infection (osteomyelitis) on Resident #45 ' s care plan had not been updated and removed. An interview was conducted on 05/04/23 at 11:00 AM with the Director of Nursing (DON). She stated the focus for pneumonia on Resident #79 ' s care plan and the focus for infection (osteomyelitis) on Resident #45 ' s care plan should have been updated and removed. 3. Resident #57 was admitted to the facility on 09/30/19 with diagnoses which included frontotemporal neurocognitive disorder. Review of Resident #57's current Preadmission Screening and Annual Resident Review (PASRR)	F 657	MDS Coordinator. All residents can be affected by this alleged deficient practice that have current pneumonia diagnosis, current infection, Level II Preadmission Screening, and/or ambulation with elopement risk. An audit was completed by Director of Nursing on 5-22-23 on current residents with current pneumonia diagnosis, current infections, LEVEL II PReadmission screening, and/or ambulation with elopement risk for accuracy of care plans. Education was completed with the Regional MDS Consultant with MDS Coordinator and Social Service Director on 5-5-23 for accuracy of care plans specifically updating and resolving care plans based on resident□s current clinical status. Regional Minimum Data Set Consultant or designee will audit five residents a week for four weeks, then five residents four times a week for four weeks and then 5 residents two times a week for three months to ensure care plans are accurate and revised based on residents□ current clinical status. The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 657	Continued From page 27	F 657		

determination letter dated 10/02/19 revealed the resident remained a level I and determined no further screening was required unless a significant changed occurred to suggest a diagnosis of mental illness.

Resident #57's annual Minimum Data Set Assessment (MDS) dated 09/08/22 indicated he was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition.

Resident #57's care plan dated 03/01/23 indicated he has a focus area of a Level II PASRR due to serious mental illness. The goal included for Resident #57 to maintain current level of function through next review date. Interventions included to adjust and meet Activities of Daily Living needs, psychotropic medication management, and he was to be seen by psychiatric services with psychotropic medication management.

An interview with the MDS Nurse on 05/04/23 at 9:45 AM revealed she did not do the care planning for level II PASRR. The social worker was responsible for completing the care plan of level II PASRR.

The Social Services Director was interviewed on 05/04/23 at 9:49 AM. She stated she was responsible for care planning PASRR levels. She stated she had only been in the position since February 2023 and was still learning the role. She stated she did not know why she had care planned Resident #57 for a level II PASRR and would have to revise the care plan.

During an interview with the Director of Nursing

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 _____	05/04/2023

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 657	Continued From page 28	F 657		

(DON) on 05/04/23 at 11:42 AM, she stated care plans should be reviewed and revised for accuracy.

4. Resident #3 was admitted to the facility 7/13/2018 with diagnoses that included Alzheimer's' dementia.

Resident #3's quarterly Minimum Data Set (MDS) dated 3/4/2023 indicated the resident was severely cognitively impaired and was dependent on staff for all activities of daily living, personal hygiene, and eating. Walking in room or corridor did not occur and she was coded with functional limitation in range of motion for both lower extremities.

Resident #3's comprehensive care plan was last revised on 4/20/2023 and contained a focus for self-care deficits related to impaired mobility, impaired vision, and impaired cognition. Interventions indicated residents were dependent upon staff to turn and reposition in bed during care rounds.

Resident #3's comprehensive care plan also included a focus for elopement risk and wandering related to impaired safety awareness. The focus was revised 4/20/2023.

An interview was conducted with NA#2 who was assigned to Resident #3 on 5/3/2023 at 1:15PM. She stated Resident #3 was not ambulatory and did not have wandering behaviors.

On 5/3/2023 at 1:25PM an interview was conducted with Unit Manager #2. She stated Resident #3 was not ambulatory and did not have wandering behaviors.

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 _____	05/04/2023

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 657	Continued From page 29 On 5/4/2023 at 9:45AM a phone interview was conducted with the Minimum Data Set (MDS) nurse who stated she revised the resident's care plan. She further stated the resident was no longer a elopement risk and the care plan should have been updated to reflect this. An interview was conducted with the Director of Nursing (DON) on 5/4/2023 at 11:13 AM. She stated the care plan should have been updated to reflect the resident's current functional ability and needs.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide nail care for 1 of 1 dependent resident (Resident #79) reviewed for activity of daily living (ADL). The findings included: Resident #79 was admitted to the facility on 11/08/22 with diagnosis that included diabetes, diabetic neuropathy. The quarterly Minimum Data Set (MDS) assessment dated 02/14/23 indicated Resident #79's cognition was fully intact. He had no behaviors and no rejection of care. He required	F 677	Resident # 79 nails were trimmed and cleaned by nursing assistant on 5-3-23. All residents with nails have the potential to be affected by the deficient practice. The Director of Nursing completed an audit on residents within the facility to ensure that residents' fingernails are clean, trimmed, and cut per residents' preferences on 5-8-23. The Director of Nursing educated the nursing department to ensure that nail care is provided for all residents on 5-5-23, to include all shifts and weekends. Any nursing staff that has not received education will not be able to work until doing so. All new hires in the nursing	6/1/23

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 _____	05/04/2023

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 677	Continued From page 30 the extensive assistance of 1 for personal hygiene. He had no functional limitations with range of motion. Resident #79's active care plan, last reviewed 02/23/23, revealed a focus that read Resident #79 had an ADL self-care performance deficit related to sepsis, diabetes, and pneumonia. The interventions indicated staff were to check nail length, trim, and clean on bath days and as necessary. A review of Resident #79's nursing progress notes from 01/01/23 to 05/02/23 revealed no refusals of nail care documented. An observation and interview were conducted with Resident #79 on 05/01/23 at 10:36 AM. Fingernails on left hand were long, extending out 1/8th to 1/4th of an inch past the tip of finger, with brown/black substance under all fingers. Fingernails on his right hand were long, extending out 1/8th of an inch past the tip of finger, with brown/black substance under all fingers except the middle finger. He stated that his fingernails needed to be cut and to be cleaned. He stated the staff have not cut them recently. An observation was conducted with Resident #79 on 05/02/23 at 8:48 AM. He was observed in his room in bed with his bedside table pulled over the left side of the bed. Fingernails were still long with black/brown substance under them. An interview was conducted on 05/03/23 at 10:20 AM with Unit Manager #2. She stated the Nursing Assistants (NAs) are responsible for cleaning and cutting residents nails during showers/baths and/or when they see that it needs to be done.	F 677	department will be educated on nail care for residents. The Unit Managers and/or Designee will complete an audit on nail care of residents care by auditing 5 residents times 5 days per week times 4 weekly then monthly times 3 months to ensure nail care has been provided to all residents. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 677	Continued From page 31	F 677		

She further stated the NAs fill out a shower sheet which includes hair care, mouth care, shaved, and nail care as tasks during the shower to be completed.

An observation was conducted on 05/03/23 at 12:10 PM with Resident #79. He was lying in bed watching television and eating lunch. Fingernails were still long with black/brown substance under them.

An observation and interview were conducted with Resident #79 on 05/03/23 at 2:54 PM. Resident #79 was observed in bed watching television and stated he had just returned from receiving a shower. He then stated the Nursing Assistant (NA) cleaned his fingernails but did not cut them. Fingernails on both hands clean with no substance under the nails. He further stated his nails need to be cut because he kept scratching himself, but that NA would be going home for the day.

An interview was conducted on 05/03/23 at 2:21 PM with Nursing Assistant (NA #3). She stated she cleaned and cut residents fingernails during the resident ' s shower days. She further stated Resident #79 was not scheduled to get a shower when she worked with him, and she did not realize his fingernails needed to be cleaned and/or cut.

An interview was conducted on 05/03/23 at 3:16 PM with Nursing Assistant (NA #1). She stated she did give Resident #79 his shower and cleaned his nails but did not have nail clippers with her and forgot to go back and cut them. She verified his fingernails needed to be cut. She then stated cleaning and cutting fingernails were 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 _____	05/04/2023

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 677	Continued From page 32 the shower sheets to be performed during showers. An interview was conducted on 05/04/23 at 11:00 AM the Director of Nursing (DON). She stated nail care was to be looked at daily and on shower days and that nails should be cleaned and cut as needed.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the failed to maintain air mattress at residents weight for 3 of 3 residents reviewed. (Resident #5, Resident #79 & Resident #26). The findings included: 1. Resident #5 was admitted to the facility on 06/16/10 with diagnosis that included cerebrovascular accident (CVA) with left sided hemiplegia (paralysis on one side of the body), furuncle on the back, diabetes, and Alzheimer ' s Disease. Resident #5 ' s active orders did not include an order for an air mattress.	F 684	Resident # 5 air mattress was removed per physician's order on 5-5-23 by wound nurse. Residents' #79 and #26 correct settings based on resident weight on 5-5-23 by wound nurse and Director of Nursing. All residents with air mattresses have potential to be affected by the deficient practice. The Director of Nursing completed an audit on air mattresses residents are using to ensure that settings are to the resident's weight by 5-20-23. The Director of Nursing inserviced	6/1/23

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 _____	05/04/2023

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 684	Continued From page 33 The quarterly Minimum Data Set (MDS) assessment dated 03/03/23 indicated Resident #5's cognition was severely impaired. She required extensive assist with bed mobility and was coded to be at risk for pressure ulcers. She had range of motion impairment to one side of her upper extremities and to both sides of her lower extremities. Resident #5's active care plan, last reviewed on 03/22/23, included a focus area for activity of daily living (ADL) self-care performance deficit related to left hemiparesis (weakness or the inability to move on one side of the body), epilepsy and Alzheimer ' s Disease. Interventions included pressure reduction mattress to bed. Review of Resident # 5 ' s weight under vital signs in her electronic record revealed a weight of 155.8 pounds (lbs) as of 05/01/23. An observation on 05/01/23 at 11:55 AM was made. Resident #5 had a low air loss mattress to her bed with the weight pressure dial set at 350 pounds (lbs). An observation on 05/02/23 at 8:22 AM was made. Resident #5 had a low air loss mattress to her bed with the weight pressure dial set at 350 pounds (lbs). Resident # 5 ' s weight as of 05/01/23 was 155.8lbs. An observation on 05/02/23 at 8:49 AM was made of the Wound Nurse adjusting Resident #5 ' s air loss mattress to the correct weight. An interview was conducted on 05/02/23 at 11:47 AM the Wound Nurse. She stated she did adjust	F 684	nursing department on the policy and procedures following physician orders to ensure that the adjusting rate on the air mattress is set based on the residents weight on 5-5-23, to include all shifts and weekends. Any nursing staff that has not received education will not be able to work until doing so. All new hires in the nursing department will be educated on accurate settings on air mattresses based on resident’s weight. The Wound Nurse will complete air mattress audit for accurate settings based on resident’s weight 5 days per weeks times 4 weeks, then monthly times 3 months to ensure air mattress are adjusted to resident weight and resident has active order in place. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 684	Continued From page 34	F 684		

the air mattress setting on Resident #5 ' s mattress because it was incorrect. She verified the air mattress setting was on 350 pounds (lbs) and that it should be set according to the resident ' s weight. She further stated the floor nurses and herself are responsible for checking air mattress pressure daily. She then stated the Nursing Assistants (NAs) adjust the weight and they should not be changing the weight dial.

An interview was conducted on 05/04/23 at 11:00 AM the Director of Nursing (DON), she stated the air mattresses should be set according to the resident ' s weight and there should be an active order for low air loss mattresses. She then stated the nurses and wound nurse were to check the pressures daily on all air mattresses in the building.

2. Resident #79 was admitted to the facility on 11/08/22 with diagnosis that included diabetes, diabetic neuropathy, and stage 2 pressure ulcer to buttock.

Resident #79 ' s active orders did not include an order for an air mattress.

The quarterly Minimum Data Set (MDS) assessment dated 02/14/23 indicated Resident #79's cognition was fully intact. He had no behaviors and no rejection of care. He required the extensive assistance of 1 for bed mobility. He had no functional limitations with range of motion. He had an indwelling catheter and was frequently incontinent of bowel.

Resident #79's active care plan, last reviewed 02/23/23, revealed no documentation of an air loss mattress.

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 _____	05/04/2023

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 684	Continued From page 35	F 684		

Review of Resident #79 ' s weight under vital signs in her electronic record revealed a weight of 144.0 pounds (lbs) as of 05/01/23.

An observation on 05/01/23 at 1:28 PM was made. Resident #79 had a low air loss mattress to his bed with the weight pressure dial set at 320 pounds (lbs).

An observation on 05/02/23 at 8:39 AM was made. Resident #79 had a low air loss mattress to his bed with the weight pressure dial set at 320 pounds (lbs). Resident # 79 ' s weight as of 05/01/23 was 144.0 lbs.

An interview was conducted on 05/02/23 at 11:47 AM the Wound Nurse. She stated she did adjust the air mattress setting on Resident #79 ' s mattress because it was incorrect. She verified the air mattress setting was on 320 pounds (lbs) and that it should be set according to the resident ' s weight. She then stated the Nursing Assistants (NAs) adjust the weight and they should not be changing the weight dial.

An interview was conducted on 05/04/23 at 11:00 AM the Director of Nursing (DON), she stated the air mattresses should be set according to the resident ' s weight and there should be an active order for low air loss mattresses. She then stated the nurses and wound nurse were to check the pressures daily on all air mattresses in the building.

3. Resident #26 was admitted on 1/15/18 and readmitted on 10/20/22 with cumulative diagnoses of a Cerebral Vascular Accident (CVA), Aphasia (inability to speak) Peripheral Artery

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 _____	05/04/2023

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 684	Continued From page 36	F 684		

Disease (PAD), history of arterial wounds and history of pressure ulcers.

Review of Resident #26's was skin integrity care plan last revised on 3/3/23 indicated he had the potential for skin issues related to fragile skin and a history of arterial wounds. Interventions did not include the use of a PRM.

Resident #26's quarterly Minimum Data Set (MDS) dated 3/12/23 read he had severe cognitive impairment, required extensive staff assistance with all of his activities of daily living (ADLs). The MDS was not coded for any skin impairments and was coded for the PRM.

Review of Resident #26's most recent weight in the electronic medical record was dated 4/4/23 and a weight of 223.5 pounds.

Review of Resident #26's May 2023 Physician orders did not include an order for a pressure relieving mattress (PRM).

Review of the PRM's operational manual read the pump setting were based on Resident #26's body weight.

An observation was completed on 5/1/23 at 11:00 AM of Resident #26. He appeared clean and absent of any evidence of discomfort. The PRM pump was set for a weight of 140 pounds.

An observation was completed on 5/1/23 at 3:40 PM. There was no change in the PRM's weight setting.

An observation was completed on 5/2/23 at 8:20 AM. There was no change in the PRM weight

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 _____	05/04/2023

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 684	Continued From page 37	F 684		

settings.

An observation was completed on 9:00 AM and the PRM was now set for a weight of 220 pounds.

An interview was completed on 5/2/23 at 8:52 AM with the Treatment Nurse. She stated Resident #26 was prescribed a PRM due to fragile skin and his history of wounds. She stated she did not adjust the PRM but Unit Manager (UM) #1 adjusted it. The Treatment Nurse stated she was responsible for checking the PRM's daily to ensure the pump settings were accurate. She was unable to explain why the PRM was set incorrectly on 5/1/23 and earlier 5/2/23. She stated if a PRM was not set according to the resident's weight, the PRM would not be an effective intervention.

An interview was completed on 5/2/23 at 9:15 AM with the Director of Nursing (DON). She stated it was the Treatment Nurse's responsibly to check the pump settings daily on all the residents on PRM's. She stated it was possible that an aide may how bumped the settings and if a resident was alert and oriented and voiced that the PRM was to firm, the resident could ask for the PRM weight settings to be adjusted. She continued that Resident #26 was not able to make such a request due his mental status and aphasia.

An interview was completed on 5/2/23 at 9:20 AM with UM #1. She stated she adjusted Resident #26's PRM pump settings this morning at approximately 8:45 AM. UM #1 stated she adjusted the PRM weight settings because it was not set according to Resident #26's actual weight.

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 _____	05/04/2023

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 684	Continued From page 38 She further stated it was her responsibility to check the PRM pump setting daily to ensure they were set accurately. An interview was completed on 5/3/23 at 8:30 AM with Nurse #3. She stated she was not aware that Resident #26's PRM weight setting were incorrect until UM #1 adjusted it yesterday. She stated it was the responsible of the Treatment Nurse to check the PRM's daily for function and accurate settings. An observation was completed on 5/3/23 at 9:00 AM of Resident #26's PRM weight setting. It was set correctly for 220 pounds. An interview was completed on 5/3/23 at 2:10 PM with Nursing Assistant (NA) #2 and NA #6. They stated the aides were not allowed to adjust the settings on the PRM's. An interview was completed on 5/4/23 at 11:10 AM with the DON and the Administrator. The DON stated Resident #26's PRM should be set according to his weight and monitored to ensure accuracy.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		6/1/23

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 _____	05/04/2023

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 695	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews and record review, the facility failed ensure continuous oxygen was in use and obtain oxygen saturation percentages as ordered (Resident #77). The facility also failed to maintain bedside suction equipment in a sanitary condition as ordered by the Physician (Resident #3) This was for 2 of 3 residents reviewed for respiratory care. The findings included: 1. Resident #77 was admitted on 11/25/22 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Resident #77's quarterly Minimum Data Set dated 1/25/23 indicated moderate cognitive impairment and coded for the use of oxygen. Review of Resident #77's respiratory care plan last revised on 2/23/23 read he had altered respiratory status related to his COPD. Interventions included to administer oxygen as ordered. Review of Resident #77's May 2023 Physician orders included an order dated 11/25/22 read oxygen at 2 liters per minute (L/M) via a nasal cannula. Titrate oxygen up if saturations drop to less than 90% every shift for oxygen monitoring. Review of Resident #77's electronic medical records revealed his oxygen saturation rates from 3/1/23 to present were not documented as having	F 695	Resident # 77 is no longer a resident within the facility. Resident #3's bedside suction equipment was changed/cleaned on 5-3-23 by certified nursing assistant and validated by unit manager. All residents with orders for oxygen and all residents to have bedside suction equipment in use have the potential to be affected by the deficient practices. Director of Nursing completed audit for all residents with oxygen orders have resident oxygen saturation percentages monitored and recorded and oxygen given as ordered and residents with bedside suctions equipment are cleaned/changed per orders on 5-22-23. The Director of Nursing inserviced Licensed Nurses on the policy and procedures on following physician orders to ensure that resident oxygen saturation percentages are monitored and recorded as ordered and oxygen given as ordered and residents with bedside suctions equipment are cleaned/changed per orders on 5-5-23, to include all shifts and weekends. Any nurse who has not received education will not be able to work until doing so All new licensed nurses will be inserviced on policy and procedures on following physician orders to ensure that resident oxygen saturation percentages are monitored and recorded as ordered	

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 _____	05/04/2023

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 695	Continued From page 40 been obtained every shift as ordered. An observation was completed on 5/1/23 at 3:40 PM of Resident #77. He was sleeping in bed wearing his continuous oxygen as ordered. An observation was completed on 5/2/23 at 9:00 AM of Resident #77. There was no change in the observation completed on 5/1/23. An interview was completed on 5/3/23 at 8:30 AM with Nurse #3. She stated Resident #77 was ordered continuous oxygen at 2 L/M. She stated there were no Physician orders to obtain any oxygen saturation percentages on Resident #77. She said his oxygen saturation were only checked whenever his vital signs were obtained. An observation was completed on 5/3/23 at 11:05 AM of Resident #77 sitting alone in the resident lounge/activity room. He had his head lying on the table with an unopened tank of oxygen missing the gauge and nasal cannula on the back of his wheelchair. An interview was completed on 5/4/23 at 11:00 Am with Nursing Assistant (NA) #8 who was assigned Resident #77 on first shift on 5/3/23 when he was found in the lounge/activity room without his oxygen. She stated she got him up yesterday but was not aware that his oxygen was continuous.	F 695	and oxygen given as ordered and residents with bedside suctions equipment are cleaned/changed per orders. The Unit Managers and/designee will complete oxygen and suction audit on resident 5 days per week times 4weeks, then monthly times 3 months to ensure oxygen and suction orders for cleaning/changing are in place and oxygen saturation are followed per orders. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 695	Continued From page 41	F 695		

An interview was completed on 5/3/23 at 11:17 AM with the MD. She stated the orders to check Resident #77's oxygen saturation levels every shift were important and needed to be obtained as ordered. She also stated Resident #77 should be wearing his oxygen at all times.

An interview was completed on 5/4/23 at 11:10 AM with the Director of Nursing (DON) and the Administrator. The DON stated Resident #77's oxygen should be administered continuously, and his oxygen saturation levels should be obtained as ordered.

2. Resident #3 was admitted to the facility 7/13/2018 with diagnoses that included Alzheimer's' dementia and dysphagia.

Resident #3's quarterly Minimum Data Set (MDS) 3/4/2023 indicated the resident was severely cognitively impaired and was dependent on staff for all activities of daily living, personal hygiene, and eating.

Resident #3's comprehensive assessment contained a focus for altered respiratory related to respiratory failure with excess secretions initiated on 11/12/2021. Interventions included maintaining a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions.

Resident #3 had the following active physician orders:

" Maintain suction set up at bedside. The start

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 _____	05/04/2023

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 695	Continued From page 42	F 695		

date was 3/18/2023.
" Suction orally as needed every hour for increased secretions. The start date was 4/30/2023.
" Change small tube between canister and suction machine monthly. Mark with date changed. Change on night shift every 1 month(s) starting on the 26th. The start date was 3/26/2023.
" Dispose of suction catheter tubing after each use. The start date was 3/18/2023.
" Change suction cannister every 72 hours or when 3/4 full. The start date was 3/18/2023.

On 5/1/2023 at 12:53PM Unit Manager #2 was observed assisting Resident #3 with her lunch meal. Suction equipment was observed sitting on a bedside dresser to the left of the bed. In the suction canister was approximately 100ml of grey fluid with a black film on top. The suction tubing had a black substance from the oral suction apparatus to the cannister. The oral suction apparatus (Yankauer) also contained a black substance.

On 5/2/2023 at 8:42AM NA #2 was observed assisting Resident #3 with her breakfast. The suction equipment was observed sitting on the bedside dresser to the left of the bed. In the suction canister was approximately 100ml of grey fluid with a black film on top. The suction tubing had a black substance from the oral suction to the cannister. The oral suction apparatus (Yankauer) also contained a black substance.

On 5/3/2023 at 1:15 PM NA#2 was observed in Resident #3's room. She could not recall the last time the suction equipment was used and it appeared no one cleaned the set up after using it.

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 _____	05/04/2023

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 695	Continued From page 43 She further stated the nurses maintain the suction equipment. The nurse assigned to Resident #3 on 5/1/2023 and 5/2/2023 was on vacation and unavailable for interview on 5/3/2023. On 5/3/2023 at 1:25 PM an interview was conducted with Unit Manager #1. She stated the nurse who typically works with Resident #3 was on vacation. She further stated she assisted Resident #3 with her meal earlier in the week but did not notice the suction equipment. Unit Manager #1 stated she did not recall the last time the suction equipment was used. The nurses were responsible for maintaining the suction equipment. She stated she believed the oversight occurred because the orders to maintain the suction equipment did not generate on the Treatment Administration Record (TAR) to prompt nurses to complete the tasks. An interview was conducted on 5/4/2023 at 11:10 AM with the Director of Nursing (DON) and the Administrator. The DON stated Resident #3's bedside suction equipment should have been maintained in a sanitary condition per the physician's orders.	F 695		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health	F 740		6/1/23

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 _____	05/04/2023

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 740	Continued From page 44 encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and Medical Director, the facility failed to provide physician ordered behavioral health services for 1 of 1 (Resident #18) reviewed for behaviors. The findings included: Resident #18 was admitted to the facility on 2/16/2023 with diagnoses that included major depressive disorder and anxiety disorder. The resident's quarterly Minimum Data Set (MDS) dated 3/10/2023 indicated the resident was moderately cognitively impaired and had no behaviors during the assessment period. The resident's comprehensive care plan was last revised on 4/3/2023 contained a focus for the use of psychotropic medications as well as a focus for level II PASSR related to serious mental illness. Resident #18's medical record contained physician orders for the following behavioral medications: " Give seroquel 75 milligram (mg) by mouth at bedtime for dementia-related psychosis. The start date was 4/17/2023. " Give namenda, 5mg, by mouth two times a day for dementia. The start date was 2/17/2023 " Give clonazepam, 0.5mg, by mouth two times a day for anxiety. The start date was 2/17/2023. " Give bupropion, 450mg, by mouth one time a day for depression. The start date was 2/17/2023.	F 740	Resident #18 received behavioral health services on 5/29/23. All residents with physician ordered behavioral health services have the potential to be affected by the deficient practice. The Director of Nursing and Social Services Director completed an audit on 5-25-23 on current residents with physician ordered for behavioral health services and referred to be seen for the services in a timely manner if not already on caseload. The Director of Nursing in serviced Licensed Nurses and Social Service Director on residents who have a physician□s order for behavioral health services have referral made in a timely manner on 5-5-23, to include all shifts and weekends. Any nurse/social service worker who has not completed the education will not be able to work until doing so. All newly hired nurses or social service workers will be in serviced on referring residents who have a physician order for behavioral health services to be referred for the services in a timely manner. The Social Services Director will audit orders for behavioral health services five times a week for four weeks and then monthly times three months for referrals made in a timely manner for behavioral health services.	

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 _____	05/04/2023

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 740	Continued From page 45 " Give escitalopram oxalate, 20 mg, by mouth at bedtime for depression. The start date was 2/17/2023. " Give Aricept, 10mg, by mouth one time a day for dementia. The start date was 2/17/2023. Resident #18's medical record also contained a physician's order dated 2/17/2023 to consult psychiatry and treat as needed. On 2/21/2023 a second physician order for behavior health was requested and read as follows; consult behavioral health for evaluation of depression, anxiety, and dementia with psychosis. Noted concerns for significant amounts of medications. A third request for psychiatric services was ordered by the physician on 3/23/2023. A fourth physician's order for psychiatric evaluation related to depression, anxiety, and dementia related psychosis was requested on 4/17/2023. Resident #18's medical record did not contain any indication the resident was ever evaluated by behavioral health professionals. On 5/3/2023 at 10:37AM an interview was conducted with the Director of Nursing (DON). She stated there were notes or evaluations by a behavioral health professional in Resident#18's medical record because she had not been evaluated by psychiatric services while a resident in the facility. The DON stated she was aware of the 4 referrals for psychiatric evaluation because she entered the order on 3/23/2023. She further stated the referrals were given to the Director of Social Services who faxed the referral to the behavioral health provider. On 5/3/2023 at 10:43 AM an interview was conducted with the Director of Social Services.	F 740	The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 740	Continued From page 46 She stated she was responsible for sending out referrals to the behavioral health providers via fax. The Director of Social Services stated she saved fax confirmations when she faxed a referral, but she was not able to locate any fax confirmations for Resident #18. She further stated there was not a process in place for confirming the referrals were completed. On 5/3/2023 at 11:18 AM an interview was conducted with the Medical Director. She stated she requested a psychiatry consult on all residents who were admitted on psychotropic or antipsychotic medications. That is why the 2/17/2023 order was requested. She stated she was not aware the facility had no process in place to ensure referrals were completed but she did try and follow up on referrals herself. The Medical Director stated the facility recently changed behavioral health providers and that may have contributed to the difficulty getting orders completed. An interview was conducted with the DON and the Administrator on 5/4/2023 at 11:19 AM. The DON stated she expected referrals to be completed. She further explained the facility was working on a performance improvement plan to ensure referrals were completed.	F 740		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		6/1/23

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 _____	05/04/2023

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 756	Continued From page 47 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff, Consultant Pharmacist, and Medical Director (MD) interviews and record review, the Consultant Pharmacist failed to identify the need for an annual MD or psychiatric Nurse Practitioner (NP) documented rationale for the continued use of a prescribed antipsychotic	F 756	Resident # 10's antipsychotic medication drug regiment review was conducted by the pharmacist on 5-9-23. No recommendations made for the provider after the review.	

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 _____	05/04/2023

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 756	Continued From page 48 medication (Geodon) at the current prescribed dosage for 1 (Resident #10) of 5 residents reviewed for unnecessary medications. The findings included: Resident #10 was originally admitted on 7/22/13 who's cumulative diagnoses included Schizoaffective Disorder. Review of a nursing note dated 3/22/22 at 3:31 PM read there were new orders to increase Resident #10's Geodon to 60 mg twice a day. There was no documentation in the electronic medical record for the rationale for increasing his Geodon. A review of Resident #10's May 2023 Physician orders included an order for Geodon 60 mg by mouth twice a day for Schizoaffective Disorder. The order was dated 3/22/22. Resident #10's antipsychotic care plan last revised on 6/7/22 for the use of the antipsychotic read it was prescribed for attention seeking behaviors, auditory/visual hallucinations/delusions and manipulative behaviors. Resident #10's last quarterly Minimum Data Set dated 3/8/23 indicated he was cognitively intact and exhibited no behaviors. He was also coded for the use of an antipsychotic medication. Review of Resident #10's Consultant Pharmacist progress notes dated 3/27/23 and 4/26/23 did not identify the need for MD or psychiatric NP documentation of the rationale for the continued dosage of Resident #10's Geodon.	F 756	All residents on antipsychotic medications have the potential to affected by the deficient practice. Pharmacy consultants audited all residents on antipsychotic medications and made Gradual dose reductions recommendations for physician notification of any recommendations as needed by 5-9-23 The Administrator educated the Pharmacy Consultant concerning the reviewing of antipsychotic medications and make gradual dose reduction recommendations for physician notification of any recommendations as needed on 5-5-23. All new hire pharmacy consultants will be educated on gradual dose reductions recommendations for physician notification of residents on antipsychotic medications. Pharmacy consultant will audit monthly residents on antipsychotic medications to make gradual dose reductions recommendations for physician notification if not contraindicated already for residents on antipsychotic medications times 3 months. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

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 _____	05/04/2023

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 756	Continued From page 49 An interview was completed on 5/3/23 at 11:17 AM with the MD. She stated the lack of annual documentation regarding the continued use of Resident #10's current Geodon dose was likely due to the Consultant Pharmacist's lack of identifying the need to reassess Resident #10's Geodon. A telephone message was left on 5/3/23 at 3:25 PM and 5/4/23 at 9:14 am for the Psychiatric NP to call surveyor. There were no return calls. An interview was completed on 5/4/23 at 10:47 AM with the Director of Nursing (DON). She stated the Consultant Pharmacist had not identified the need for the MD or psychiatric NP to provide annual documented rationale for the continued dose of Resident #10's Geodon at the ordered dosage. A telephone interview was completed on 5/4/23 at 3:26 PM with the Consultant Pharmacist. He stated since the Resident was followed by psychiatry, he did not make any recommendations regarding the need for annual MD or psychiatric NP documentation of the rationale of Resident #10's current dose of Geodon.	F 756	Date of Compliance: June 1, 2023	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to reconstitute (the	F 760	Resident # 17's IV Antibiotic was not reconstituted by nurse on 05/02/2023. IV	6/1/23

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 _____	05/04/2023

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 760	Continued From page 50 process of adding a diluent to a dry ingredient to make it a liquid) an intravenous (IV) antibiotic prior to administration for 1 of 1 resident (Resident #17) reviewed for IV antibiotic administration. The findings included: Resident #17 was admitted to the facility on 9/14/2022. The resident's quarterly Minimum Data Set (MDS) dated 1/5/2023 indicated Resident #17 was cognitively intact, required extensive assistance for all activities of daily living, was always incontinent of urine, and received diuretics 7 out of 7 days during the assessment period. Resident #17's comprehensive care plan was last updated 4/27/2023 and included a focus for risk of complications related to urinary tract infection with positive cultures. Resident #17's medical record included a physician's order for Meropenem (antibiotic) intravenous solution to be reconstituted and 1 gram administered intravenously three times a day for extended spectrum beta-lactamase (ESBL) urinary tract infection. The start date was 4/27/2023 with an end date of 5/8/2023. On 5/2/2023 at 10:17 AM the resident was observed lying in her bed with an intravenous line running from an empty 50 milliliter (ml) bag of normal saline to a peripherally inserted central catheter (PICC). The glass vial of Meropenem was observed to have dry white powder still in the vial. Nurse #3 was interviewed. She stated she hung the antibiotic at 8:00AM and was coming in	F 760	reconstituted antibiotic was given to Resident #17 on 5/2/23 by licensed nurse. Nurse # 3 has been provided with 1:1 education on IV antibiotics by Director of Nursing on 5-5-23 to ensure that glass adapter is reconstituted per MD orders to prevent a medication error. All residents who receive IV medications have the potential to be affected by the deficient practice. Director of Nursing completed an audit of all residents who were on IV antibiotics on 5-8-23 and no other resident was on IV antibiotic medication. The Director of Nursing inserviced Licensed Nurses on reconstitution of antibiotics administration of IV antibiotics prior to administration on 5-5-23, to include all shifts and weekends. Any nurse who has not completed the education will not work until doing so. All new hired licensed nurses will be inserviced on how to reconstitute an IV antibiotic prior to administration. Unit Managers and/or designee will complete weekly audits on reconstitute IV antibiotic prior to administration all shifts times weekly times 4 weeks and then monthly times 3 months. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality	

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 _____	05/04/2023

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 760	Continued From page 51 the room to discontinue the infusion and flush the PICC line. Nurse #3 observed the IV set up and was unable to identify the antibiotic had not been reconstituted. When the error was pointed out, Nurse #3 stated she must have forgotten to reconstitute the medication prior to hanging and administering the medication. She further stated she would have the unit manager to hang another bag. On 05/04/2023 at 9:08 AM an interview was conducted with Unit Manager #1. She stated Nurse #3 made her aware the Meropenem had not been reconstituted prior to administration. She further stated nurses had received education on how to reconstitute antibiotics in glass vials using an adaptor. She believed it was an oversight by the nurse and not a lack of education. On 5/03/2023 10:49 AM an interview was conducted with the Nurse Practitioner. She stated she was not made aware of the missed medication administration. On 5/03/2023 at 11:21 AM an interview was conducted with the Medical Director. She stated she was not made aware of missed medication administration on 5/2/2023. An interview was conducted on 05/04/2023 at 11:13 AM with the Director of Nursing (DON). She stated Resident #17 should have received her IV antibiotic per physician's order. She believed more education regarding administration should be provided to nursing staff.	F 760	Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/1/23

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 _____	05/04/2023

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 761	Continued From page 52 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to label medications with the date they were opened on 1 of 2 medication carts (the Greenbrier Hall Medication Cart). Findings included: A. An observation was conducted on 05/02/23 at 4:01 PM of the nurse ' s medication cart on the Greenbrier Hall in the presence of Nurse #2. The	F 761	No resident was affected by the deficient practice. Undated insulin pen and multi-dose insulin bottles were removed from cart on 5/2/23. All residents have the potential to be affected by the deficient practice who receive medication requiring dating when opened. Medication carts audited by the Unit Managers on 5/8/23 for medications requiring dating when opened to ensure dated when opened.	

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 _____	05/04/2023

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 761	Continued From page 53 observation revealed one multi-dose Glargine Insulin pen with no opened date. Nurse #2 verified the multi-dose Glargine insulin pen did not have an opened date labeled and was removed from the medication cart. B. An observation was conducted on 05/02/23 at 4:01 PM of the nurse ' s medication cart on Greenbrier Hall in the presence of Nurse #2. The observation revealed 2 multi-dose bottles of Humulin R Insulin with no opened date. Nurse #2 verified 2 multi-dose vials of Humulin R Insulin did not have an opened date labeled and were removed from the medication cart. An interview was conducted on 05/02/23 at 4:11 PM with Nurse #2. She stated she hadn't noticed the insulins were not dated. She also stated that she opened the multi-dose Glargine insulin pen on a different day but must have forgotten to write the opened date on the pen. She stated insulin should be labeled and dated when opened. An interview was conducted on 05/04/23 at 11:00 AM with the Director of Nursing (DON). She stated nurses were to date all insulin vials and pens upon opening and they should be checking dates daily prior to administration.	F 761	Director of Nursing in serviced all licensed nurses on labeling and dating medications when opened on 5-5-23, to include all shifts and weekends. Any nurse who has not completed the education will not work until doing so. All new licensed nurses will be in serviced on labeling and dating medications when opened by the Director of Nursing. Unit Managers and/or designees will audit medication labeling and dating of medications weekly for four weeks and then monthly times three months. The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for three consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		6/1/23

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 _____	05/04/2023

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 812	Continued From page 54 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure leftover food items were labeled and dated in 1 of 1 walk-in refrigerators and failed to ensure the low temperature dish machine a reached a minimum temperature of 120 degrees Fahrenheit during the wash cycle. This practice had the potential to affect food served to all residents. The findings included: 1. During the initial kitchen tour of the walk-in refrigerator on 05/01/23 at 10:00 AM the following concerns were observed: - a container of leftover spaghetti was sealed with plastic wrap, unlabeled, and undated - a container of chicken noodle soup was sealed with plastic wrap, unlabeled, and undated - a container of chili beans was sealed with plastic wrap, unlabeled, and undated - a container of cooked rice was sealed with plastic wrap, unlabeled, and undated - a large cooked ham was wrapped in aluminum foil, unlabeled, and undated	F 812	No resident was affected by the deficient practice. Certified Dietary Manager removed all unlabeled and undated food items on 5-1-23. Dishwasher was repaired on 5-2-23. Certified Dietary Manager started paper products for food delivery on 5-1-23 due to low temperature reading below 120 degrees Fahrenheit on low temperature dish machine during wash cycle. All residents have the potential to be affected by the deficient practice. Certified dietary manager completed an audit on all of the leftover food items in the refrigerator and audit on dishwasher temperature and temperature on dishwasher machine minimum 120 degrees Fahrenheit No food items outdated by 5-2-23 for unlabeled/dated leftover food items found and no temperature on dishwasher machine below 120 degrees Fahrenheit noted during wash cycle.	

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 _____	05/04/2023

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 812	Continued From page 55 - a package of turkey deli meat was opened and undated - a package of cheddar cheese was opened and undated During an interview with the Dietary Manager (DM) on 05/01/23 at 10:05 AM, he stated those items should have been labeled and dated. He stated he has told staff in the past to label and date items when they are opened but did not know why those items were not labeled or dated at the time of the observation. The Administrator was interviewed on 05/04/23 at 11:47 AM. She stated the refrigerator should be checked daily and all food items should be labeled and dated. 2. A continuous observation of the kitchen's low temperature dish machine with the Dietary Manager (DM) on 05/01/23 between 2:50 PM and 3:00 PM revealed a Dietary Aide was working at the dish machine, pre-rinsing and feeding dirty kitchenware, which included 6 plate covers and 3 clear plastic dishes into the dish machine. The machine's wash temperature gauge read a registered temperature of 115 degrees Fahrenheit. The DM then used a calibrated thermometer to check the dish machine's water temperature. The internal wash temperature reached 107 degrees Fahrenheit. During an interview with the DM on 05/01/23 at 3:00 PM, he stated the dish machine was supposed to read 120 degrees Fahrenheit according to the temperature log sheet the facility follows. He stated temperatures should be taken after breakfast, lunch, and dinner. He stated he could not locate the temperature log for 05/01/23	F 812	Administrator provided 1:1 inservice with Dietary Manager of leftover food items are to be labeled and dated in walk-in refrigerators and outdated/unlabeled food items removed and ensure low temperature dish machine maintains a minimum temperature of 120 degrees Fahrenheit during the wash cycle on 5-5-23. The Dietary Manager educated dietary staff on labeling and dating leftover food items in walk-in refrigerator and ensure low temperature dish machine maintains a minimum temperature of 120 degrees Fahrenheit during the wash cycle and recording on temperature log of temperature reading daily on 5-11-23 and for new hire on 5-30-23, to include all shifts and weekends. Any dietary staff who has not completed education will not be able to work until doing so. All new hires will be educated on dating and labeling food items when opened and low dish machine temperature is to be maintained a minimum temperature of 120 degrees Fahrenheit during the wash cycle and recording on temperature log of temperature. Dietary Manager will audit refrigerators for date and labeling of open leftover food items and temperature logs of low temperature dish machine maintain 120 degrees Fahrenheit during the wash cycle 5 times per week times 4 weeks, then monthly times 3 months. The Dietary Manager or designee will	

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 _____	05/04/2023

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 812	Continued From page 56 and did not know how long the temperature gauge had been reading 115 degrees Fahrenheit. The Dietary Aide was not available for interview. An interview was completed with the Administrator on 05/04/23 at 11:47 AM. The Administrator stated she expected the dish machine to be in working order and at the correct temperature for sanitation.	F 812	bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: June 1, 2023	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		6/1/23

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 _____	05/04/2023

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 867	Continued From page 57	F 867		

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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 _____	05/04/2023

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 867	Continued From page 58	F 867		

performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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 _____	05/04/2023

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 867	Continued From page 59 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey completed on 05/04/23. This was for 5 deficiencies that were cited in the areas of resident rights, notice requirements before transfer, accuracy of assessments, care plan timing and revision, and drug regimen review. The duplicate citations during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. 550-Based on observations, record reviews, and staff interviews, the facility failed to provide a dignified dining experience by referring to a resident who needed assistance with meals as a "feeder" (Resident #59) .This was for 1 of 2 residents reviewed for dignity. Based on the reasonable person concept residents would not expect to be identified as a "feeder". During the facility's recertification survey of 09/30/21, the facility failed to promote dignity by not providing privacy during an insulin injection	F 867	The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put into place following the recertification survey May 2023 in regard to residents rights, notice requirements before transfer, accuracy of assessments, care plan timing and revisions, and drug regimen review. Plan of correction was put in to place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated in-service to all administrative staff on 5-29-23 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective	

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 _____	05/04/2023

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 867	Continued From page 60 and by standing while assisting a dependent resident during a meal. This was for 2 of 2 residents reviewed for dignity. 2. 623- Based on record review, Responsible Party interview, and staff interviews, the facility failed to notify the resident and/or the responsible party (RP) in writing of the reason for the transfer/discharge to the hospital for 2 of 2 sampled residents reviewed for hospitalizations (Residents #14 and #10). During the facility's recertification survey of 09/30/21, the facility failed to provide the resident and/or responsible party (RP) written notification of the reason for a hospital transfer for 3 of 3 residents reviewed for hospitalization. 3. 641- Based on staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of behaviors for Resident #59 and continence for Resident #5. This was for 2 of 17 residents reviewed for MDS accuracy. During the facility's recertification survey of 09/30/21, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of falls, medications, nutrition, restraints, and demographics. This was for 7 of 17 residents reviewed. 4. 657- Based on record review and staff interviews, the facility failed to review and revise the care plans in the areas of pneumonia (Resident #79), infection (Resident #45), ambulation (Resident #3) and level 2 Pre-Admission Screening and Resident Review (PASRR) (Resident #57). This was for 4 of 17	F 867	action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. The Quality Assurance Performance Improvement Committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: June 1, 2023	

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 _____	05/04/2023

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 867	Continued From page 61 residents reviewed for care plans. During the facility's recertification survey of 09/30/21, the facility failed to review and revise care plans in the area of falls and in the area of isolation precautions. This was for 2 of 17 resident care plans reviewed. 5. 756-Based on staff, Consultant Pharmacist, and Medical Director (MD) interviews and record review, the Consultant Pharmacist failed to identify the need for an annual MD or psychiatric Nurse Practitioner (NP) documented rationale for the continued use of a prescribed antipsychotic medication (Geodon) at the current prescribed dosage for 1 (Resident #10) of 5 residents reviewed for unnecessary medications. During the facility's recertification survey of 09/30/21, the facility failed to identify the need for target behaviors for the use of psychotropic medications. This was for 4 of 5 residents reviewed for unnecessary medications. An interview was completed on 05/04/23 at 11:10 AM with the Administrator. She stated she felt the repeat citations were due to the facility's recent staff changes in nursing management and not having a full time Minimum Data Set (MDS) Nurse at the facility.	F 867		