STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 in conjunction with a complaint investigation survey was conducted from 4/29/24 through 5/2/24. The facility was found in compliance with the requirement of CFR. 483.73 Emergency Preparedness. Event ID #7KD011.	E 000		
F 000	INITIAL COMMENTS A recertification survey and a complaint investigation survey was conducted onsite from 4/29/24 through 5/2/24. Event ID # 7ZSE11. The following intakes were investigated: NC 00213748, NC 00208396, NC 00216439, NC 00211274, NC 00213012, NC 00213969, NC 00214101, NC 00210904, NC 00213293, NC 00215690, NC 00216301, NC 00216476, NC 00216332, NC 00214218, NC 00213174, NC 00216373. 8 of the 32 complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		5/29/24

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

Electronically Signed | 05/27/2024

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F 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility 1a) failed to repair torn floor linoleum in resident rooms (513 and 515), 1b) failed to remove the black greenish substance from the commode base caulking in resident rooms (511, 513, 515, 606, and 608), 1c) failed to repair a broken free standing clothes cabinet doors in resident rooms (510, 513, and 608), 1d) failed to repair leaking commode bases in resident rooms (506, 511, 513, 515, 608, 612, and 615), 1e) failed to replace broken or missing	F 584	1. Residents' rooms 513 and 515 floor linoleum was replaced on 5-23-24 by Maintenance Director. Black greenish substance from commode base caulking in resident's rooms 511,515,606, and 608 were replaced by 5-23-24 by the Maintenance Director. Broken free standing clothes cabinet doors in residents' rooms 510, 513, and 608 were repaired by the maintenance Director on 5-21-24. Leaking commode bases in	

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F 584	Continued From page 2 bathroom door threshold strip in resident rooms (500, 510, 612, 613, and 615), 1f) failed to replace broken or missing toilet paper dispensers in resident rooms (612), 1g) failed to repair resident's overhead lights that were either non-functioning, missing a light cover, or had broken light covers in rooms (515 and 601), 1h) failed to replace broken window blinds in resident rooms (515, 606, and 608); and 2a) failed to eliminate a strong urine and feces odor noted on the 500 and strong urine odor on the 600 hall which was also detected in residents' rooms. These failures occurred on 2 of 6 hallways (500 Hall and 600 Hall) observed for a safe, clean, homelike environment. Findings included: 1a. An initial observation on 04/30/24 at 8:30 AM revealed torn floor linoleum in resident rooms (513 and 515). 1b. An observation on 04/30/24 at 8:30 AM revealed resident commodes (511, 513, 515, 606, and 608), were noted to have black greenish substance located around the base of the commodes. 1c. An observation on 04/30/24 at 8:30 AM revealed broken free standing clothes cabinet door broken (510, 513, and 608). 1d. An observation on 04/30/24 at 8:30 AM revealed resident room commodes were leaking at their bases with strong sewage smell emanating from the leaking toilets in rooms (506, 511, 513, 515, 608, 612, and 615). 1e. An observation on 04/30/24 at 8:30 AM	F 584	residents' rooms 506,511, 513, 515, 608, 612, and 615 repaired by Maintenance Director on 5/24/24. Broken or missing bathroom door threshold strip in residents' rooms 500,510,612,613,and 615 replaced by Maintenance Director on 5/27/24. Broken or missing toilet paper dispenser in resident room 612 replaced on 5/27/24 by Maintenance Director. Overhead lights either nonfunctioning, missing light cover, or had broken light covers in rooms 515 and 601 will be replaced/repaired by 5/27/24 by the Maintenance Director. Broken window blinds in resident rooms 515, 606, and 608 were replaced by Maintenance Director by 5/22/24. Urine/feces odors on 500 hall and 600 hall were corrected by Environmental Service Director on 5/13/24. 2. All residents have the potential to be affected by the deficient practice. Administrator conducted a facility wide audit of all residents' rooms on repair/replace, clean odor free/homelike environment on 5/21/24. 3. Inservice conducted by Nursing Home Administrator on 5/6/24 with Maintenance Director, Maintenance Assistant, and Environmental Service Director of repair/replace, clean and odor free/homelike environment of residents' rooms and notification reporting on TELS system of irregular findings. Inservice conducted by Maintenance Director to all staff by 5-27-24 of TELS reporting of repair/replacement, odor free, homelike environment of irregular findings. All new	

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F 584	Continued From page 3 revealed resident rooms with broken or missing bathroom door threshold strip (500, 510, 612, 613, and 615). 1f. An observation on 04/30/24 at 8:30 AM revealed broken or missing toilet paper dispensers in resident rooms (612). 1g. An observation on 04/30/24 at 8:15 AM revealed overhead lights that were either non-functioning, missing a light cover, or had broken covers in rooms (515 and 601). 1h. An observation on 04/30/24 at 8:30 AM revealed broken window blinds in resident rooms (515, 606, and 608). An interview and observation was conducted on 04/30/24 at 3:45 PM with the Maintenance Director (MD). The MD stated there were multiple areas on the 500 and 600 halls that still needed to be addressed, repaired, or replaced. He stated he had an assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes on the 500 and 600 halls and did not know about the leaking commodes. He said maintenance was responsible for repairing or replacing items in the facility, and that the stained or torn bathroom linoleum needed to be repaired, along with the other items that were pointed out to him during the 500 and 600 hall tour. A follow-up facility tour was conducted on 05/01/24 at 10:20 AM of the 500 and 600 halls with the Administrator. The tour revealed: Black greenish substance around the base of resident commodes, leaking commodes, torn linoleum, missing or broken threshold strips, broken above	F 584	orientees will be inserviced on TELS reporting system for notification of repair/replacement, odor free, homelike environment. 4.Weekly for twelve (12) weeks the Maintenance Director/maintenance assistant will monitor residents' rooms for safe, clean, odor free homelike environment environment. The results of the audit will be presented by Maintenance Director to the monthly Quality Assurance Process Improvement (QAPI) meeting for three (3) months. The QAPI committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 584	Continued From page 4	F 584		

bed lights, broken toilet paper dispenser, broken resident clothing cabinets, and broken blinds. She stated the areas observed on the 500 and 600 halls needed to be addressed and fixed.

2a. An observation on 04/30/24 at 8:35 revealed a strong smell of urine and feces which was detected in a resident's room (room 514) and throughout the 500-hallway. This odor was also evident in Resident #50 and Resident #73's room located in the 500-hall on 04/30/24 and 05/01/24.

A follow-up observation was conducted on 04/30/24 at 9:45 AM on the 500 and 600 hallways and Room 514 and was noted to smell strongly of urine and feces.

An interview was conducted on 04/30/24 at 8:40 AM with Resident #50. Resident #50's Minimum Data Set dated 02/17/24 revealed the resident had no cognitive impairments. She stated there was always a strong odor of urine and feces in their room and the 500-hall. She said she let staff and administration know about the strong odor for at least the last 6-months, and still, it smelled awful. She said she had to ask staff to keep the hallway door shut most of the time due to the strong odor.

An interview was conducted with Resident #73 Resident #73's Minimum Data Set dated 02/17/24 revealed the resident had no cognitive impairments. on 04/30/24 at 8:40 AM. She stated there was always a strong odor of urine and feces in the hall, which seeps into her room. She said she let staff and administration know of the strong odor for a long time and it still smelled awful. She said she kept her door shut most of the time due to the strong foul odor.

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F 584	Continued From page 5	F 584		

A follow-up observation was conducted on 04/30/24 at 9:45 AM of the 500 and 600 halls. Strong urine and feces odor was still present in the two hallways.

An interview and observation were conducted on 04/30/24 at 3:45 PM of the 500 and 600 halls with the Maintenance Director. He stated the 500 and 600 halls odor needed to be addressed.

A follow-up facility tour was conducted on 05/01/24 at 10:20 AM of the 500 and 600 halls with the Administrator. The Administrator said the strong urine odor down the 500 and 600 halls were never brought to her attention by staff or residents.

An interview on 05/02/24 at 11:00 AM with the Administrator revealed that she was not aware of the strong odor of urine down the 500 and 600 halls. She stated that the facility was working hard to keep the facility clean and odor free.

An interview on 05/02/24 at 11:10 AM with the Director of Nursing revealed that she was aware that occasionally there was urine odors down the 500 and 600 halls, but she felt that the strong odor down the 500-hall was from a resident with an ostomy, which is a hole in the abdominal wall allows waste to leave the body and collects the waste in a bag.

An interview on 05/02/24 at 12:00 PM with Nursing Assistant (NA) #11 revealed that she worked on the 500-hall frequently. She stated that the urine smell was bad on 500-hall. She stated staff would spray down the hall but felt they did not have enough housekeeping staff, or they

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F 584	Continued From page 6	F 584		

weren't doing their job.

An interview on 05/02/24 at 12:08 PM with NA #10 revealed that she worked on the 500-hall at times. She stated that the 500 and 600 halls usually had a strong urine odor, but in the last couple of days it has been better since surveyors were in the facility.

An interview on 05/02/24 at 12:10 PM with NA #9 revealed that she worked on the 500 and 600-halls. She stated the two halls had a strong urine odor.

An interview was conducted with the Administrator on 05/02/24 at 5:15 PM. She revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. She said there were still areas in the facility that still needed to be addressed and they were actively putting plans in place through their Quality Assurance and Performance Improvement (QAPI) plan to address those areas she observed during the survey. She said her additional concerns included: repair and paint needed in resident rooms/bathrooms, repair or replace of commodes, and repair or replace of any other identified physical plant concerns that needed to be addressed. She said she was not sure where the strong odors down the 500 and 600 halls were coming from but did say a few of the residents' bathrooms had strong urine and feces odor which could have been caused by leaking toilets, the black greenish substance from the commode base caulking, or from the stained torn linoleum around the bases of some of the commodes observed. The Administrator stated it was her expectation for all the residents to have a

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F 584	Continued From page 7 safe and homelike environment that was clean and in good repair. 2b. An initial tour of the facility was conducted on 04/29/24 at 10:55 AM. Prior to entering the 600 hall, which was noted to have an entry way where the 600 hall was to right of the entrance, a very strong odor of urine was detected. Once on 600 hall the odor was stronger and more pungent. There was a dirty linen bin and a trash bin noted on each end of the hall. Each bin had a closed lid, and they were not overflowing with dirty linens. A room deodorizing wall unit was noted to be in place at the top end of the 600 hall. An interview was conducted with Resident #49 on 04/29/24 at 11:00 AM. Resident #49 was alert and oriented and resided on the lower end of the 600 hall. Resident #49 stated the urine smell was so bad at times, she had to keep her door closed. Resident #49 stated some days were worse than others and today (04/29/24) it was bad. Resident #49 stated the strong odor had been present for a couple of months. Resident #49 stated she notified the nursing staff of her concerns regarding the odor in the past but she did not	F 584		

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F 584	Continued From page 8	F 584		

think anything was done about it.

An interview was conducted with Housekeeper #1 on 04/29/24 at 11:17 AM. Housekeeper #1 stated she noticed the urine odor as well, but she did not have any more room deodorizer on her cart to spray in the hall way. Housekeeper #1 was not sure if the deodorizer on the wall was working or if it needed to be refilled. She stated the Maintenance Director managed the unit.

An observation of the 600 hall during the lunch meal on 04/29/24 at 1:07 PM revealed the urine odor was still strong and pungent prior to entering the 600 hall entrance and while walking through the 600 hall. The dirty linen bins and the trash bins were not on the units during this observation.

An observation of the 600 hall on 04/29/24 at 4:10 PM revealed the urine odor remained strong and pungent and unchanged.

An observation of the 600 hall on 04/30/24 at 1:30 PM revealed the urine odor remained strong and pungent and unchanged. There was a dirty linen bin and a trash bin noted on each end of the hall. Each bin had a closed lid, and they were not overflowing with dirty linens.

An interview was conducted with the Maintenance Director on 05/01/24 at 1:55 PM. The Maintenance Director stated he did not notice the smell because he had sinus issues. He stated the wall unit deodorizers were put in place to help with the odor. At this time, he checked the unit to make sure the canister was full of deodorizer and that the unit was in working condition. The Maintenance Director stated the unit was working and had plenty of deodorizer in the canister. He

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F 584	Continued From page 9 stated the unit will send off a small mist every 5 minutes. While standing near the unit and while it was misting, the odor it sent out was very light and barely noticeable. The Maintenance Director stated he could not smell the deodorizer but felt that he was desensitized to it. An interview was conducted with the Administrator on 05/02/24 at 5:00 PM. The Administrator stated the facility was actively working on making improvements to the 600 hall to improve the environment and she thought that the odor had improved.	F 584		
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- (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	F 623		5/29/24

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F 623	Continued From page 10	F 623		

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 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

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F 623	Continued From page 11 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 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 and staff interviews, the facility failed to provide written notification of discharge or transfer to the resident and their Responsible Party (RP) of the reason for discharge to the hospital for 1 of 1 sampled resident (Resident #102) reviewed for	F 623	1. Written notification of discharge or transfer to hospital and reason mailed to responsible party of resident # 102 on 5-23-24. Resident no longer resides in the facility.	

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(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 hospitalization. Findings included: Resident #102 was admitted to the facility on 12/18/23. The admission Minimum Data Set dated 12/24/23 revealed Resident #102 was cognitively intact. Review of Resident #102's medical record revealed she was transferred to the hospital on 01/14/24. No written notice of discharge was documented to have been provided to the resident or her Responsible Party (RP). An interview was conducted on 05/01/24 at 8:30 AM with Social Worker #1. The Social Worker stated she was not aware that a written notification of discharge needed to be provided in writing to the resident and RP and was never directed to do so. An interview was conducted on 05/02/24 at 7:55 AM with the Administrator. The Administrator stated that the facility notified the RP by phone and was not aware that a written notification of discharge needed to the resident and RP.	F 623	2.All residents discharged or transferred to the hospital have the potential to be affected by the deficient practice. 3. Social Service Director/Social Service Assistant inserviced by Nursing Home Administrator on 5/13/24 of notification of discharge or transfer and reason for transfer to resident/responsible party. Social Service Director completed look back audit on 4/29/24 through 5/14/24. Seven residents went out, none received notification of transfer. Notifications of transfer or discharge to the hospital and reason completed by 5/21/24. 4. Weekly for twelve (12) weeks the Social Service Director or Social Service Assistant will audit residents transferred or discharged to the hospital to validate notifications of transfer or discharge and reason are sent to the resident/responsible party. The results of the audits will be presented by Social Service Director to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for three (3) months. The QAPI will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 641 SS=E	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:	F 641		5/29/24

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 641	Continued From page 13 Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of Hospice services, respiratory care, nutrition and weight loss, unnecessary medications, and communication and sensory for 5 of 35 residents whose MDS assessments were reviewed (Residents #19, #47, #35, #17 and # 1). Findings included: 1. Resident #35 was admitted to the facility on 3/27/17 with diagnosis which included in part vascular dementia with behaviors and dementia with agitation. Review of Resident #35's electronic health record revealed a 1/23/24 Physician Assistant progress note which indicated a problem of debility with decline and was followed by Hospice. Review of Resident #35's electronic health record revealed a Hospice progress note dated 2/1/24. Further review of Resident #35's health record revealed a Hospice Team Care Plan Hospice program note which indicated resident was admitted to Hospice services on 10/20/23 and continued to receive Hospice services. Review of Resident #35's 2/1/24 quarterly Minimum Data Set (MDS) assessment revealed Hospice services while a resident was coded as No. An interview was conducted on 5/1/24 at 3:35 PM with the MDS Coordinator. The MDS Coordinator stated it was an error that Hospice was not coded on the 2/1/24 quarterly MDS assessment.	F 641	1.Resident #35 quarterly Minimum Data Set (MDS) assessment reference date (ARD) 2/1/24 was modified on 5/1/24 by MDS coordinator to reflect the accuracy for hospice. Resident #47 annual MDS ARD 4/5/24 was modified on 5/2/24 by MDS coordinator to reflect the accuracy for weight loss. Resident #17 annual MDS ARD 2/23/24 was modified on 5/1/24 by MDS coordinator to reflect the accuracy for antipsychotic medications. Resident #1 annual MDS ARD3/30/24 was modified by MDS Coordinator on 5/20/24 to reflect the accuracy for hearing. Resident #19 quarterly MDS ARD 1/29/24 was correctly coded per the treatment administration record by MDS Coordinator. CPAP use was reflected in Item O011G1 of the MDS (Non-Invasive Mechanical Ventilator). No modification was indicated. 2.Residents receiving hospice services, experiencing weight loss, receiving antipsychotic medications, or with hearing impairment have been identified as having the potential to be affected. These residents had their MDS audited by the MDS Coordinator and the Social Service Director to validate accuracy of the MDS per the Resident Assessment Instrument (RAI) Manual. Audit was completed on 5/21/24. 3. MDS Coordinators were educated on 5/16/24 by the Director of Nursing on MDS coding sections K0300, N9450A, and O0110K1 per the RAI Manual. Social Workers were educated on 5/16/24 by the	

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F 641	Continued From page 14 An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS assessments would be completed accurately. 2. Resident #47 was admitted to the facility on 6/14/18 with medical diagnosis stroke, diabetes, and dysphagia (swallowing difficulty). The following weights were recorded in Resident #47's electronic medical record: 1/2/24 150.0 lbs. wheelchair 1/8/24 147.8 lbs. chair scale 1/10/24 142.0 lbs. wheelchair 2/2/24 190.8 lbs. wheelchair 3/6/24 190.5 lbs. chair scale 3/18/24 192.2 lbs. wheelchair scale 3/25/24 192.6 lbs. mechanical lift scale 3/27/24 152.8 lbs. wheelchair scale 4/3/24 156.0 lbs. sitting. Review of Resident #47's 4/5/24 annual Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairment and a weight of 156 pounds. Resident #47's assessment was coded as had no weight loss or gain in the past 30 days or 180 days. An interview was conducted on 5/2/24 at 3:05 PM with the MDS Coordinator. The MDS Coordinator revealed that she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual and Resident #47's 4/5/24 MDS assessment was coded in error. An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS	F 641	Director of Nursing on MDS coding of section B0200 per the RAI Manual. 4. Weekly for twelve (12) weeks the MDS Coordinator will audit three (3) MDS's per week to validate coding per the RAI Manual of residents receiving hospice services, experiencing weight loss, receiving antipsychotic medications, or with hearing inmpairment. Results of the audits will be presented by the MDS Coordinator in the monthly QAPI meeting for three (3) months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 641	Continued From page 15	F 641		

assessments would be completed accurately.

3. Resident #19 was admitted to the facility on 9/3/13 with diagnosis which included obstructive sleep apnea, obesity hypoventilation syndrome, chronic obstructive pulmonary disease, asthma, and chronic congestive heart failure.

Review of Resident #19's physician orders revealed an order dated 9/2/23 to place Continuous Positive Applied Pressure (CPAP) 10 centimeters water on resident every night at bedtime related to obstructive sleep apnea. Remove per schedule.

Review of Resident #19's January 2024 Medication Administration Record (MAR) revealed entries for CPAP every night apply at bedtime related to obstructive sleep apnea were recorded.

Review of Resident #19's 1/29/24 quarterly Minimum Data Set (MDS) indicated oxygen was received while a resident. CPAP while a resident was not coded on Resident #19's MDS.

An interview was conducted on 5/2/24 at 3:05 PM with the MDS Coordinator. The MDS Coordinator revealed that Resident #19's 4/5/24 MDS assessment was coded in error, and it was a mistake that CPAP was not coded.

An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS assessments would be completed accurately.

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F 641	Continued From page 16	F 641		

4. Resident #17 was admitted to the facility on 06/21/19 with diagnoses that included dementia with agitation and behavioral disturbance.

The MDS assessment dated 02/23/24 for Resident #17 documented antipsychotic medication was not received on a daily basis.

Review of the February 2024 Medication Administration Record for Resident #17 revealed he had been administered the antipsychotic medication Risperidone 1 milligram (mg) each morning and Risperidone 2.5 mg each evening.

In an interview with the MDS Coordinator on 05/01/24 at 13:46 PM she stated the assessment was coded incorrectly and should have been coded to reflect that Resident #17 had received an antipsychotic medication on a daily basis.

In an interview with the DON on 05/02/24 at 4:00 PM she stated she expected the MDS assessments to be coded correctly.

5. Resident #1 was admitted to the facility on 05/03/23. Diagnoses included hearing loss.

The Minimum Data Set annual assessment dated 03/30/24 revealed Resident #1 was cognitively intact and was coded as having adequate hearing.

A review of Resident #1's care plan revealed a plan of care dated 4/3/23 for at risk for communication declines related to hard of hearing.

During an interview with Resident #1 on 04/29/24

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F 641	Continued From page 17 she stated she was very hard of hearing and to speak loudly or write down any questions. Resident #1 reported she had hearing aids, but she did not wear them because they did not work right. An interview with Social Worker #1 on 05/02/24 at 2:15 PM revealed Resident #1 has been extremely hard of hearing since admission. Social Worker #1 confirmed he coded Resident #1 inaccurately regarding her hearing and instead of adequate it should have been coded as severely impaired. An interview with the Administrator on 05/02/24 at 5:30 PM revealed she expected the MDS assessments to accurately reflect the resident's condition.	F 641		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		5/29/24

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F 690	Continued From page 18 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to use a clean washcloth and clean water to provide catheter care for 1 of 1 resident reviewed for an indwelling urinary catheter (Resident #61). Findings included: Resident #61 was admitted to the facility on 01/02/24 with diagnoses which included: Sacral ulcer stage-4, osteomyelitis of sacral area, urinary tract infection, and had an indwelling urinary catheter. A review of Resident #61's hospital discharge orders dated 01/02/24 included: Continue indwelling urinary catheter on discharge to assist stage-3 or 4 sacral and perineal wound healing in the incontinent patient.	F 690	1. Resident #61 is currently being provided proper catheter care as per skilled checklist procedure using clean washcloth. 2. Residents with indwelling foley catheters have been identified as having the potential to be affected. By 5/23/24 all four (4) residents with indwelling catheters were observed with certified nursing assistant performing proper catheter care. 3. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Nursing Supervisors and Unit Manager conducted educational in-services with all nursing staff. including agency staff, for proper catheter care. After 5/24/24 no nursing staff member, including agency, will be permitted to work	

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F 690	Continued From page 19 A review of Resident #61's most recent care plan dated 04/09/24 revealed: Resident #61 required staff assistance with activities for daily living related to history of ulcers and had an indwelling urinary catheter related to wound healing stage-4 wound. A review of Resident #61's most recent Minimum Data Set dated 04/10/24 indicated resident #61 was cognitively intact and had an indwelling urinary catheter. A wound physician note dated 04/30/24 for Resident #61 revealed the patient had an indwelling urinary catheter, which both need to be cleaned and dressed daily. A bed bath and indwelling urinary catheter care observation with NA #8 was conducted on 05/01/24 at 10:20 AM. The NA #8 was observed washing Resident #61's upper arms, chest, abdomen, thighs, and groin area. Then NA #8 with the same washcloth and basin of water proceeded to wipe the penis and indwelling urinary catheter tubing. An interview was conducted with NA #8 on 05/02/24 at 10:10 AM. NA #8 revealed she was trained to use a clean washcloth and clean water when cleaning around the penis and indwelling urinary catheter tubing. NA#8 stated she should have used a clean washcloth and emptied out the basin of dirty water and replaced it with clean water and she didn't. She said she did not bring in enough supplies to complete the bath and indwelling urinary catheter care and only brought in one washcloth. She said she did not know why she did not go and get more linen supplies or why she did not change out the basin's dirty water but	F 690	without receiving the education by the Staff Development Coordinator, Assistant Director of nursing, Unit Manager or Nursing Supervisor. During their classroom orientation, newly hired licensed nurses and certified nursing assistants will be educated on the importance of catheter care and using clean washcloth. Once a week for twelve (12) weeks the Director of Nursing, Assistant Director of Nursing, Unit Manager, Nursing Supervisors will audit each resident with a indwelling foley catheter to validate the proper care of catheters was provided. If improper catheter care is observed, the assigned certified nursing assistant or licensed nurse will be removed from resident care until one-to-one re-education is completed with the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator. 4. The Director of Nursing will present the audits to the QAPI Committee monthly for twelve (12) weeks or as directed by the QAPI Committee. The QAPI committee will review the audits and make recommendations or revisions to the plan to assure compliance is sustained ongoing.	

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F 690	Continued From page 20 knew she should have. An interview was conducted with the Director of Nursing (DON) on 05/02/24 at 11:15 AM. The DON indicated that indwelling urinary catheter care was done every shift. She revealed as a part of indwelling urinary catheter care the indwelling urinary catheter tubing should be cleansed using fresh water and a clean washcloth. The DON revealed all facility residents should receive proper peri care and indwelling urinary catheter care as well as monitoring for infection. An interview was conducted with the Administrator on 05/02/24 at 5:15 PM. The Administrator stated she expected staff to perform indwelling urinary catheter care correctly.	F 690		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		5/29/24

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F 692	Continued From page 21 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Registered Dietician (RD) and Physician Assistant (PA) interviews, the facility failed to 1.) obtain and record accurate weights per physician order and verify the accuracy of a resident with a significant change in weight (Resident #47), and 2.) obtain weekly weights according to the physicians order and provide nutritional supplements for a resident with weight loss (Resident #81). This occurred for 2 of 2 residents reviewed for nutrition (Resident # 47 and Resident # 81). The findings included: 1). Resident #47 was admitted to the facility on 6/14/18 with medical diagnosis stroke, diabetes, and dysphagia (swallowing difficulty). Review of Resident #47's electronic health record revealed a 3/10/23 physician order for Osmolite 1.5 100 cubic centimeters (cc's) per hour for 13 hours daily related to moderate protein calorie malnutrition and dysphagia. The order was discontinued on 3/10/24. The following weights were recorded in Resident #47's electronic medical record: 1/2/24 150.0 pounds (lbs.) wheelchair 1/8/24 147.8 lbs. chair scale 1/10/24 142.0 lbs. wheelchair scale 2/2/24 190.8 lbs. wheelchair scale Review of Resident #47's electronic health record	F 692	1. Resident #47 weekly weights are obtained and accurate. Resident #81 is receiving supplements ordered by the physician and accurate weights are documented. 2. Resident with physician orders for weekly weights have been identified has having the potential to be affected. On 5/17/24 all weight scales were professionally calibrated to ensure equipment is in working order for accurate weights. As of 5/23/24 weekly weights are being obtained for the identified residents. On 5/23/24 designated and trained certified nursing assistants were chosen to obtain all weekly weights ordered by the physician. Any weight obtained will be reviewed by the Unit Manager prior to entering the weight into the computer system and then to follow facility protocol for notification of any resident indicated for weight loss. 3. On 5/23/24 all licensed nurses and certified nursing medication aides and certified nursing assistants were educated by the Staff Development Coordinator, the Director of Nursing, Assistant Director of Nursing, Unit Manager, and nursing supervisor to ensure weights are obtained per physician order, and how to perform obtaining weights for accuracy.	

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F 692	Continued From page 22 revealed a 2/19/24 physician order for weekly weights. The following weights were recorded in Resident #47's electronic medical record: 2/19/24 no weight recorded. 2/26/24 no weight recorded. 3/6/24 190.5 lbs. chair scale Review of Resident #47's electronic health record revealed a 3/10/24 physician order for Osmolite 1.5 100 milliliters per hour for 12 hours daily related to moderate protein calorie malnutrition and dysphagia. The following weights were recorded in Resident #47's electronic medical record: 3/13/24 no weight recorded. 3/18/24 192.2 lbs. wheelchair scale 3/25/24 192.6 lbs. mechanical lift scale 3/27/24 152.8 lbs. wheelchair scale 4/3/24 156.0 lbs. sitting. 4/7/24 136.0 lbs. wheelchair scale 4/14/24 no weight recorded. 4/21/24 no weight recorded. 4/28/24 no weight recorded. No weight was recorded during the survey. Review of Resident #47's 4/5/24 annual Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairment, weight of 156 pounds, with no weight loss or gain and received all nutrition via feeding tube. A revised 4/17/24 care plan focus indicated Resident #47 had a nutritional problem related to malnutrition with a history of weight fluctuations	F 692	4. Weekly for twelve (12) weeks the Assistant Director of Nursing or the Director of Nursing or nursing administration designee will audit residents with physician orders for weekly weights to validate weights were obtained pr physician's order. Results of the audits will be presented by the Director of Nursing in the monthly QAPI meeting for three (3) months. The QAPI committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 692	Continued From page 23	F 692		

with dysphagia and needing all nutrition via tube feeding. An intervention indicated Resident #47 was to be weighed at the same time of the day and recorded per the physician order.

Review of Resident #47's electronic health record revealed a dietary progress note dated 4/30/2024. The registered dietician (RD) progress note indicated weight and enteral review for resident was completed. Resident with significant weight loss in the past 1 month, previously with significant weight gain. The RD note indicated to monitor weight trends and adjusted the nutrition plan of care with recommendations as appropriate.

An interview was conducted with Nursing Assistant (NA)# 2 on 5/1/24 at 11:55 AM. NA # 2 indicated she was frequently assigned to Resident #47. NA #2 stated the nursing assistants were responsible for obtaining and recording the weights. NA # 2 stated the nurse informed the NAs which residents needed to be weighed each day. NA #2 stated she often did not have enough time during her shift to obtain resident weights, including the weights for Resident #47..

An interview was conducted with the Registered Dietitian (RD) on 5/1/24 at 3:20 PM. The RD stated she had observed inaccurate weights and had a concern regarding the accuracy of the weights. The RD stated she expected the weight would be stable for a resident that received enteral feeding for their primary nutrition. The RD stated she was not sure if the weights recorded for Resident #47 were accurate. The RD stated if a resident had a significant weight change, a reweigh should be obtained as soon as possible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 692	Continued From page 24	F 692		

after the change was observed. The RD further stated if a resident had an order for weekly weights, she expected the weights to be obtained and recorded. The RD indicated accurate weights were important for evaluation of Resident #47's tube feeding and nutritional status. The RD stated the weights recorded for Resident #47 were questionable.

An interview was conducted with the Director of Nursing (DON) on 5/1/24 at 4:30 PM. The DON stated the facility had recently started a performance improvement plan on weights.

Review of the Quality Assurance Performance Improvement (QAPI) program provided by the DON indicated a 4/16/24 plan was initiated for weight management and accuracy of weights. The plan indicated weights would be accurate and entered timely and followed up on accordingly. Interventions and systemic changes indicated weights would be reviewed monthly by the DON prior to data entry to alert for any questionable inaccuracies for reweight, prior to entering in the electronic medical record. The plan indicated no in-service training was implemented with staff. Monthly Quality Assurance Performance Improvement (QAPI) will review compliance with weight plan and make recommendations. QAPI will review for 3 months or longer as needed.

An interview was conducted on 5/2/24 at 10:30 AM with the Unit Manager. The Unit Manager revealed there had been issues with the weights. The Unit Manager stated the nurse informed the NA each day which residents required weights to be obtained. The Unit Manager indicated the Director of Nursing was responsible for reviewing

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 692	Continued From page 25	F 692		

the weights.

An interview was conducted with the Physician Assistant (PA) on 5/2/24 at 12:05 PM. The PA revealed she was not aware that weekly weights were not obtained on Resident #47 and was not aware of the weight change for the resident. The PA stated she expected that weights would be obtained according to the order, and she expected a resident receiving tube feeding would not exhibit weight changes. The PA further indicated she expected a reweigh would be obtained when a change in weight was observed.

A follow-up interview was conducted with the Director of Nursing on 5/2/24 at 3:30 PM. The DON indicated she expected that weights would be obtained per physician orders and would be accurate. The DON stated there was a systems process failure that caused the problems with weights not being obtained as ordered or not accurate.

2.) Resident #81 was admitted to the facility on 04/26/23 with diagnoses including dementia, chronic kidney disease, heart disease, and dehydration.

A care plan dated 04/27/23 for Resident #81 revealed the potential for alteration in hydration and nutrition related to requiring fortified foods, dementia, and chronic kidney disease. The goal of care was to maintain adequate nutritional status. Interventions included in part to provide and serve nutrition supplements as ordered and obtain weights per protocol.

A physicians order dated 05/03/23 for Resident

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 692	Continued From page 26	F 692		

#81 was to obtain weekly weights every Wednesday for monitoring.

Review of Resident #81's weights recorded in the electronic medical record revealed the following:

05/01/2024	120.0 Lbs.
04/07/2024	122.8 Lbs.
03/13/2024	128 .1 Lbs.
03/01/2024	125.2 Lbs.
02/28/2024	126.4 Lbs
02/15/2024	130.8 Lbs
02/01/2024	131.4 Lbs
01/31/2024	130.6 Lbs
01/18/2024	131.8 Lbs
12/27/2023	140.7 Lbs
12/20/2023	140.6 Lbs
11/29/2023	142.1 Lbs
11/22/2023	142.0 Lbs
11/15/2023	141.5 Lbs
11/08/2023	137.6 Lbs
10/25/2023	141.4 Lbs
10/18/2023	141.5 Lbs
10/11/2023	141.6 Lbs
10/04/2023	176.0 Lbs
09/20/2023	176.0 Lbs
08/30/2023	173.6 Lbs
08/23/2023	173.6 Lbs
08/09/2023	172.4 Lbs.
08/02/2023	174.1 Lbs
07/26/2023	169.4 Lbs
07/19/2023	169.2 Lbs
07/12/2023	169.1 Lbs
07/01/2023	169.2 Lbs
06/28/2023	168.1 Lbs
06/21/2023	168.0 Lbs
06/14/2023	168.1 Lbs
06/07/2023	168.0 Lbs
06/02/2023	168.8 Lbs.

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 692	Continued From page 27	F 692		

05/31/2023 167.4 Lbs
05/24/2023 166.2 Lbs
05/10/2023 170.3 Lbs
05/03/2023 170.3 Lbs.

A physicians order dated 02/23/24 for Resident #81 revealed Fortified diet and Nutritional Supplement three times a day for supplement to be provided on the meal tray.

The Minimum Data Set (MDS) annual assessment dated 04/13/24 revealed Resident #81 had severely impaired cognition. She required staff assistance with activities of daily living. She had weight loss and received a therapeutic diet. She had no rejection of care.

During an observation on 04/29/24 at 1:00 PM Resident #81 was observed lying in bed. She could not answer detailed questions regarding her nutrition. Her family member was at the bedside and stated she usually visited daily for lunch. She reported her appetite was poor. There was no nutritional supplement provided on the meal tray.

During an observation on 04/30/24 at 9:15 AM Resident #81 was observed lying in bed. There was no nutritional supplement on her breakfast tray. Her breakfast meal included eggs, sausage, and milk.

During an observation on 04/30/24 at 01:59 PM Resident #81 was observed lying in bed. Her family member was at the bedside and stated she visited daily during lunch, and she had not been receiving supplements lately. She stated with her

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 692	Continued From page 28	F 692		

poor appetite she thought the supplements would benefit her.

During an interview on 05/01/24 at 03:29 PM the Dietary Manager stated she did not have the order for the nutritional supplement in her order system for Resident #81 and that was why it did not populate on the meal slip. She indicated she did not know why it was missed and was not in her system. She stated she would correct the order immediately and ensure Resident #81 was provided the nutritional supplement three times a day on her meal tray.

During a phone interview on 05/02/24 at 10:15 AM the Registered Dietician indicated she last reviewed Resident #81 on 04/09/24 and she had weight loss. She reported Resident #81 received a fortified diet, appetite stimulants, and nutritional supplements. She indicated there had been issues with weight consistencies and they had discussed this in the Interdisciplinary Team (IDT) meetings. She reported she was not aware Resident #81 was not receiving the nutritional supplement according to the order that was dated February 2024. She stated they recently did audits of the nutritional supplements 2 or 3 weeks ago and thought they had captured any inconsistencies and didn't know how this was missed. She stated the Dietary Manager spoke with her yesterday about this order and it was corrected. She reported she didn't know what the miscommunication was regarding not obtaining weekly weights for Resident #81. She stated weekly weights were needed to assess for weight loss and the nutritional supplement should be provided according to the order.

During an interview on 05/02/24 at 12:05 PM

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 692	Continued From page 29	F 692		

Nurse Aide #8 stated the nurse would write on the assignment sheet which residents needed to be weighed each day. She stated Resident #81 was weighed in a weight chair or with the mechanical lift. She stated she usually gets her to stand up with 2-person assistance to obtain her weight. Once she gets the weight she reports it to the nurse. She stated she relied on the nurses to notify the nurse aides of who needed weights each day. She stated Resident #81 did get a nutritional supplement sometimes but not consistently and stated the nutritional supplements were provided by the Kitchen staff. She stated she looked at the meal slips most of the time to make sure the diet was accurate, and everything was on the tray. She indicated she didn't realize Resident #81 was supposed to get a nutritional supplement with each meal.

During an interview on 05/02/24 at 11:00 AM the Physician Assistant stated she evaluated Resident #81 today and she was not aware weekly weights weren't getting done. She indicated Resident #81 was at risk for nutritional decline and had weight loss and expected weights to get done according to the order. She stated she was not aware she was not receiving the nutritional supplement with each meal and expected she received the nutritional supplement three times a day.

During an interview on 05/02/24 at 12:32 PM the Unit Manager stated there had been issues with obtaining weights. She stated the nurse was supposed to let the nurse aides know each day who needed weights. She reported they tried to get the weights on the residents' shower days. They had discussed getting a weekly weight

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 692	Continued From page 30 schedule posted behind the nurses station so that staff could see who needed weights done. She indicated more work was needed to improve the process for obtaining weights. She stated the nutritional supplements were provided by the Kitchen staff and should have been provided on Resident #81's meal tray. During an interview with the Director of Nursing (DON) on 05/02/24 at 10:45 AM she stated they had identified an issue with obtaining weights and accuracy of weights. She stated they had been working on correcting the process. She stated they were now having nurse aides obtain weekly weights on shower days so that if the resident refused, they could get the weight on the next shower day that week due to residents getting showers twice a week. She indicated more work including education was needed to correct their process. She stated weights should be obtained and nutritional supplements provided according to the physicians order.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		5/29/24

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 693	Continued From page 31 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to store the plastic plunger and plastic syringe used for the administration of water and medications separated resulting in the potential for bacterial growth for 1 of 2 residents (Resident #47) reviewed for feeding tube. Findings included: Resident #47 was admitted to the facility on 6/14/18 with medical diagnosis which included stroke and dysphagia (swallowing difficulty). Review of Resident #47's 4/5/24 annual Minimum Data Set assessment revealed the resident had severe cognitive impairment. The resident was coded as having had a feeding tube and received 51% or more of her total calories through a feeding tube. In addition, the resident was coded as received 501 cubic centimeters (cc) or more of fluid intake through a feeding tube. An observation was conducted of Resident #47's feeding equipment on 4/29/24 at 2:48 PM. The observation revealed a syringe stored with the plunger inside the syringe in a clear plastic bag	F 693	1. On 5/2/24 a new Piston syringe set up was given to resident #14. All four (4) residents with enteral feedings were checked for proper storage of the piston syringe set up in that the plunger was separated from the syringe. 2. Residents with enteral feedings has been identified as having potential to be affected by the deficient practice. All five (5) residents with enteral feeding were screened for proper piston syringe set ups. 3. By 5/23/24 all licensed nurses have been educated on the importance of separating the piston from the syringe to prevent bacteria. All agencies were notified to have all licensed nurses educated on the procedure of separation of the piston plunger from the syringe. All agency licensed nurses will have education completed by 5/23/24. Any licensed nurse must have education completed prior to enteral feeding med pass. During orientation any new licensed nurses will have the education on proper	

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F 693	Continued From page 32 hanging on an intravenous pole. The syringe had visible liquid in the tip of the syringe. An observation was conducted of Resident #47's feeding equipment on 5/1/24 at 11:55 AM. The observation revealed a syringe stored with the plastic plunger inside the syringe in a clear plastic bag hanging on an intravenous pole. The syringe had visible liquid in the tip of the syringe. An observation was conducted of Resident #47's feeding equipment on 5/2/24 at 10:05 AM. The observation revealed a syringe stored with the plastic plunger inside the syringe in a clear plastic bag hanging on an intravenous pole. The syringe had visible liquid in the tip of the syringe. An interview was conducted on 5/2/24 at 10:10 AM with Nurse # 2. Nurse # 2 revealed she was assigned to Resident #47. The nurse stated she flushed Resident #47's feeding tube and administered medications that morning. The nurse stated upon completion of the administration of the medications and the water flush she had put the plunger and syringe together and placed them back in the bag hanging on the intravenous pole. An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed she expected that the plunger and syringe would be stored separately after use and they would not be stored with liquid in the syringe.	F 693	storage of piston syringes. 4. Weekly for twelve (12) weeks the Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Nursing Supervisor will audit all residents with enteral feedings per week to validate that the piston plunger is separated from the syringe. The results of the audits will be presented by the Director of Nursing to the monthly QAPI meeting for three (3) months. The QAPI Committee will review the audits and make recommendations to assure compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility	F 732		5/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 732	Continued From page 33 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate nurse staffing information for 18 of 106 days reviewed (October	F 732	1.Accurate and complete nursing staffing data is currently posted in the facility. The facility is currently utilizing and posting the	

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 732	Continued From page 34 1, 2023 through April 30, 2024) and failed to complete a Daily Staffing Form on one day (12/25/23) for staffing. Findings included: A review of the nursing staff posting (report of nursing staff directly responsible for resident care) from 10/01/23 through 04/30/24 was conducted. The staff posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00 PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses (CNAs), the census (# of residents in the facility) actual hours worked, and a column for staffing totals. A review of the actual working assignment sheets compared to the daily staff posting sheets from 10/01/23 through 04/30/24 revealed 18 of the staff posting sheets were noted to have discrepancies of actual nursing staff that were physically in the facility working at the beginning of each shift including the RNs, LPNs, and CNAs. Staff posting were not accurate on the following dates: 11/27/23, 12/08/23, 12/26/23, 12/27/23, 02/27/24, 03/02/34, 03/03/24, 03/22/24, 03/24/24, 03/26/24, 03/27/24, 03/28/24, 03/29/24, 04/02/24, 04/25/24, 04/17/24, 04/20/24 and 04/29/24. No Daily Staffing Form was completed on 12/25/23. An interview was conducted with the Scheduler on 05/02/24 at 12:25 PM. She stated that one possibility the postings were not accurate was because she filled out the posting at the beginning of the day and when staffing changed the postings were not adjusted. She also explained she left at 5:00 PM and if a change in	F 732	staffing forms daily. The staffing forms are currently being secured in the facility for the regulatory timeframe of eighteen (18) months. 2. Residents residing in the facility have the potential to be affected by the deficient practice. 3. The Administrator provided education to the Staffing Coordinator, Director of Nursing, Assistant Director of Nursing, Nursing Supervisor on having accurate and complete nurse staffing data, posting the foms daily, and assuring the forms for 18 months. 4.The Director of Nursing or Assistant Director of Nursing will conduct audits twice a week for twelve (12) weeks to validate accurate and complete nursing staffing data, posting the forms daily and securing the forms for eighteen (18) months. Results of the observational audits will be presented by the Director of Nursing in the monthly QAPI meeting for three (3) months. The QAPI committee will review the observational audits and make recommendations based on the findings to assure compliance is sustained ongoing.	

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	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 732	Continued From page 35 the number of nursing staff occurred after she left or on the weekend, other staff may not have known to adjust the staff posting. She stated she had worked from home on 12/25/23, no administrative staff were on duty, and the nursing staff in the building did not complete a Daily Staffing Form. An interview was conducted on 05/02/24 at 1:30 PM with the Scheduler and the Human Resources Manager. The Human Resources Manager stated she could not explain why the excessively low weekend staffing triggered on the PBJ (Payroll Based Journal) Staffing Data Report for October 1, 2023 through December 31, 2023. She stated weekends had not been short staffed and review of the actual working schedules for October 1, 2023 through December 31, 2023 showed staffing was not short. She thought that because Agency staff did not always punch the time clock and the facility did use a lot of Agency staff on the weekends that the report may not have correctly represented the number staff who were working. In an interview with the Administrator on 05/02/24 at 4:30 PM she stated she expected the staff posting to be accurate every day. She reiterated the facility did not work short staffed on the weekends.	F 732		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		5/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 757	Continued From page 36 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Physician Assistant interviews the facility failed to discontinue an order for the antibiotic Clindamycin and an opioid medication Oxycodone. This resulted in the resident receiving 16 additional doses of the Clindamycin and 15 additional doses of the Oxycodone. This occurred for 1 of 5 residents reviewed for unnecessary medications (Resident #401). Findings included. Resident #401 was admitted to the facility on 04/22/24 with diagnoses that included cellulitis of the left lower limb and history of opioid dependence. The hospital discharge summary dated 04/22/24 included orders for Resident #401 for Clindamycin 150 milligrams (mg) take 3 capsules	F 757	1. On 5/2/24 the Physician discontinued Resident #401 Clindamycin and reviewed the Oxycodone order and made changes to the order. 2. All residents who have transcribing medication orders have the potential to be affected. On5/17/24 the Director of Nursing, Assistant Director of Nursing, Unit Manager, Nursing Supervisor, and MDS Coordinator conducted a facility wide baseline audit to ensure all medications are entered in correctly into each resident Electronic Health Record (EHR) to prevent unnecessary drugs. 3. Director of Nursing and/or Assistant Director of Nursing to review daily audit reports for validation of transcription orders. On or before 5/23/24, the Staff	

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F 757	Continued From page 37 (450 mg) by mouth every 8 hours for 4 days. The hospital discharge summary dated 04/22/24 included orders for Oxycodone 5 mgs immediate release. Take one tablet by mouth every 4 hours as needed for pain for up to 5 days. Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days. Clindamycin was initialed as administered to Resident #401 on the following dates and times which resulted in Resident #401 receiving 16 additional doses. The order should have been discontinued after 12 doses. 04/22/24 at 11:00 PM 04/23/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/24/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/25/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/26/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/27/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/28/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/29/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/30/24 at 7:00 AM, 3:00 PM, and 11:00 PM Review of the Medication Administration Record (MAR) dated May 2024 revealed Clindamycin was administered to Resident #401 on the following dates and times: 05/01/24 at 7:00 AM, 3:00 PM, and 11:00 PM 05/02/24 at 7:00 AM Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Oxycodone 5 mgs give 1 tablet by mouth every 4 hours as needed for pain for 4	F 757	Development Coordinator, Director of Nursing, Unit Manager, or Nursing Supervisor in charge provided education to each licensed nurse on following physician orders and transcribing accurately into the resident EHR in order to ensure residents are free from unnecessary drugs. Any licensed nurse who did not receive the education by 5/23/24 will not be permitted to work and will receive it before their next scheduled shift starts. No licensed nurse will be permitted to work after 5/23/24 without receiving education. Any newly hired licensed nurse will receive the similar education. The night shift licensed nurse will print out the medication report to audit and ensure all orders transcribed into the resident EHR are accurate and per physician order. 4. The daily night audits will occur daily for the next twelve (12) weeks to ensure residents are free from unnecessary drugs. The Director of Nursing will provide the results of the daily audits to the QAPI committee monthly for the next three (3) months. The QAPI Committee will make recommendations as needed to ensure all residents are free from unnecessary drugs.	

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F 757	Continued From page 38	F 757		

days. Oxycodone 5 mgs as needed was initialed as administered to Resident #401 on the following dates and times. The order should have been discontinued on 04/26/24.

04/22/24 at 10:43 PM
04/23/24 at 05:21 AM and 01:30 PM.
04/24/24 at 06:24 AM and 08:20 PM.
04/25/24 at 04:14 AM, 09:28 AM, and 03:46 PM.
04/26/24 at 06:22 AM, 01:22 PM, and 08:52 PM.

04/27/24 at 06:33 AM, 01:14 PM and 09:22 PM.
04/28/24 at 08:01AM and 03:34 PM.
04/29/24 at 12:15 AM, 09:36 AM, and 05:14 PM
04/30/24 at 05:50 AM, 10:21 AM, 02:34 AM, and 06:33 PM.

Review of the Medication Administration Record (MAR) dated May 2024 revealed Oxycodone 5 mgs was administered to Resident #401 on the following dates and times:

05/01/24 at 04:39 AM, 10:52 AM, and 2:25 AM.
05/02/24 at 07:00 AM.

During an interview on 05/02/24 at 2:00 PM Nurse #3 acknowledged that she was the nurse that entered the orders from the hospital discharge summary for Resident #401 and indicated she should have entered a date for the Clindamycin to be discontinued after 4 days and entered a date for the Oxycodone to be discontinued after 5 days. Nurse #3 indicated that if she did not enter dates for discontinuing the medications for Resident #401's Clindamycin or Oxycodone that it was done in error.

During an interview on 05/02/24 at 10:30 AM the Physician Assistant stated the order for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 757	Continued From page 39 #401's Clindamycin and Oxycodone should have been discontinued according to the hospital discharge summary. During an interview on 05/02/24 at 4:43 PM the Director of Nursing (DON) stated she was not aware the orders for Resident #401 were not discontinued according to the physicians order. She stated she expected the nursing staff to follow the hospital discharge summary and enter orders correctly. She indicated the nurses or unit managers entered medications into the electronic medical record. She stated the physician would be notified and education would be provided on medication administration.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5%. There were 3 medication errors observed out of 25 opportunities which resulted in a medication error rate of 12%. This occurred for 2 of 3 residents reviewed during a medication pass observation. (Resident #401, #84). Findings included. a.).During a medication pass observation on 05/01/24 at 10:00 AM with Medication Aide #1	F 759	1. Resident #3, 10, 91,401 and 84 are currently receiving their medications per physician orders. 2.Residents who have physician's orders for medications have been identified as having the potential to be affected. On 5/17/24 the Staff Development Coordinator, the Director of Nursing, the Assistant Director of Nursing, Unit Manager, MDS Coordinator, and the nursing supervisors conducted a facility wide audit of all residents' medications	5/29/24

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F 759	Continued From page 40 revealed Resident #401 was administered Oxycodone 5 milligrams (mg) for pain. Resident #401 was also administered Clindamycin (antibiotic) 150 mgs for infection. During the medication reconciliation on 05/01/24 of Resident #401's medications revealed a physicians order dated 04/22/24 for Oxycodone (opioid pain medication) 5 mgs give one tablet by mouth every 4 hours as needed for pain for 5 days. This order should have been discontinued on 04/27/24 but remained on the Medication Administration Record (MAR) and was administered to Resident #401 during the observation. During the medication reconciliation on 05/01/24 of Resident #401's medications revealed a physicians order dated 04/22/24 for Clindamycin 150 mgs give 3 capsules (450 mgs) by mouth every 8 hours for 4 days for cellulitis. This order should have been discontinued on 04/26/24 but remained on the Medication Administration Record (MAR) and was administered to Resident #401 during the observation. b.). During a medication pass observation on 05/01/24 at 09:15 AM with Medication Aide #1 revealed Resident #84 was administered Omeprazole 40 mgs for gastroesophageal reflux disease (GERD). His breakfast meal tray was delivered to him at the time Medication Aide #1 administered the medication and he began eating. During the medication reconciliation on 05/01/24 of Resident #84's medications revealed a physicians order dated 03/27/24 for Omeprazole 40 mgs give one capsule by mouth daily at least	F 759	orders to ensure they are free from medication errors. This includes ensuring blood pressure parameters were followed, any medication that was ordered a stop date was followed as ordered by the physician, and any resident with orders for Omeprazole were given as per Physicians orders. 3. On or before 5/23/24 the Staff Development Coordinator, Director of Nursing, Unit Manager, or nurse supervisor in charge provided education to each licensed nurse and certified medication aide following physician's orders to prevent medication orders. This includes stop dates on antibiotics and controlled medications, to complete full course of antibiotics as ordered and following physicians' orders for antihypertensive medications with blood pressure parameters, and Omeprazole ordered with appropriate times of administration to be administered per guidelines. Any licensed nurse or certified medication aide who did not receive the education by 5/23/24 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse or certified medication aide will be permitted to work after 5/23/24 without receiving the education. Any newly hired licensed nurse, newly hired certified medication aide, agency licensed nurse or certified medication aide will receive the same education. 4.Four times weekly for twelve (12) weeks	

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F 759	Continued From page 41 30 minutes before breakfast. Review of Resident #84's Medication Administration Record (MAR) dated May 2024 revealed Omeprazole 40 mgs was scheduled for administration at 7:00 AM. During a phone interview on 05/02/24 at 2:00 PM Medication Aide #1 stated she did not know the orders for Resident #401's Clindamycin and Oxycodone should have been discontinued and not administered on 05/01/24. She indicated the medications populated on the MAR to be administered and she gave them. She stated Resident #84's Omeprazole was administered late because she had other medications to administer during that time. During an interview with the Director of Nursing on 05/02/24 at 2:30 PM she stated she was not aware the medications for Resident #401 should have been discontinued but remained on the MAR. She stated the physician would be notified and the medications would be discontinued. She stated Omeprazole should have been administered to Resident #84 at least 30 minutes before his meals. She stated they would review the administration time and adjust it. She stated medication orders should be followed and education would be provided to nursing staff on medication administration.	F 759	the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in charge will randomly observe ten (10) residents' medication administration pass to validate medications were administered per order. If it is noted that the process was not followed, the Licensed Nurse or certified medication aide will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing or Staff Development Coordinator. The Licensed Nurse or Certified medication aide will not be premitted to provide patient care until they can correctly state the facility's process for ordering and administering medication. Additionally, daily for four (4) weeks, a facility wide observational audit of the Electronic Medical Record Dashboard will be performed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in charge to assure each resident's medication is administered per physician order. The audits will be presented by the Director of Nursing to the facility's QAPI Committee for review for three (3) months. The facility's QAPI Committee will make recommendations as needed to assure compliance is sustained ongoing.	
F 760 SS=E	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	F 760		5/29/24

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F 760	Continued From page 42 by: Based on record review, staff, Pharmacy Consultant, and the Physician Assistant interviews the facility failed to: 1a) administer an as needed antihypertensive medication as prescribed by the physician for blood pressure greater than 160 millimeters of mercury (mm Hg) resulting in 2 missed doses (Resident #3), and 1b) failed to check a blood pressure prior to administering an antihypertensive medication with parameters to hold the medication if systolic (the top number of a blood pressure reading that measures the pressure in the arteries when the heart beats) blood pressure was less than 100 (Resident #3), and 2) failed to check a resident's blood pressure prior to administering a scheduled nitrate medication used to treat angina (chest pain) with parameters to hold the medication if systolic blood pressure was less than 100 (Resident #10), and 3.) administer the full course of the oral antibiotic Ciprofloxacin prescribed for treatment of a urinary tract infection according to the Physicians order (Resident #91), and 4.) discontinue an order for the antibiotic Clindamycin and an opioid medication Oxycodone. This resulted in the resident receiving 16 additional doses of Clindamycin and 15 additional doses of Oxycodone. This occurred for 4 of 5 residents reviewed for medication administration. Findings included: 1a. Resident #3 was admitted to the facility on 06/05/22. Diagnoses included, in part, stroke with left side weakness and high blood pressure. The Minimum Data Set quarterly assessment dated 04/03/24 revealed Resident #3 was	F 760	1. On 5/2/24 Resident #10 completed the course of antibiotics as per physician's order. Resident #3 is having blood pressure taken prior to administration of antihypertensive medications as per physician order. Resident #91 completed antibiotic therapy per physician interim order on 5/2/24 and Oxycodone order was changed to hydrocodone on 5/2/24. 2. Residents who have physician's orders for antibiotics, antihypertensive, and medications with stop dates have been identified as having the potential to be affected. 3. On or before 5/23/24 the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in charge provided education to each licensed nurse and certified medication aide on medication administration policy pertaining to following physician orders. Any licensed nurse or certified medication aide who did not receive the education by 5/23/24 will not be permitted to work and will receive the education prior to the start of the next scheduled shift. No licensed nurse or certified medication aide will be permitted to work after 5/23/24 without receiving the education. The staff development coordinator, Director of Nursing, Unit Manager, or Nursing Supervisor in charge provided education to each licensed nurse and certified medication aide on actions to take if antibiotic is not readily available on	

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F 760	Continued From page 43 cognitively intact. A review of the physician orders for Resident #3 revealed an order written on 01//18/23 for Clonidine HCl (high blood pressure medication) oral tablet 0.1 milligrams give one tablet every 6 hours as needed for hypertension if systolic blood pressure greater than 160 mm/hg. A review of the blood pressure recordings for Resident #3 for February 2024 revealed on 02/15/24, Resident #1's blood pressure was recorded at 5:27 AM on 02/15/24 by Nurse #7 as 189 /93 mm/hg and on 2/15/24 at 10:25 AM as 172 / 88 mmHg by Nurse #1. A review of the February Medication Administration Record revealed the Clonidine 0.1 milligram was not administered as ordered on 02/15/24 by Nurse #7 or Nurse #1. Nurse #7 no longer worked at the facility and was unavailable for interview. Nurse #1 was interviewed on 05/02/24 at 9:37 AM and she reported when a medication was administered it was signed off in the medication administration record and a check mark would appear with the nursing initials. She stated if there was no checkmark or initials then it was not given. She stated in regard to the Clonidine 0.1 mg on 02/15/24, she said she may have given the medication to Resident #3 but could not say with 100% certainty because she did not sign it off. She stated it was important to sign off any medication that was administered so nursing staff would know that a medication was given and could monitor for effectiveness. Nurse #1 reviewed the blood pressure recordings and	F 760	5/23/24. Any licensed nurse or medication aide who did not receive the education by 5/23/24 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No licensed nurse or certified medication aide will be permitted to work after 5/23/24 without receiving the education. On 5/23/24 all physicians, nurse practitioners, and physician assistants were made aware to verify the nursing staff that the antibiotic ordered was readily available for administration and the next steps to be made in the electronic medication record. Eachlicensed nurse and certified medication aide will have a medication administration pass competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor completed on or before 5/23/24. Any licensed nurse and certified medication aide who does not pass the medication administration pass competency will have immediate one to one re-education and will not be permitted to work without direct supervision by the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor. The Licensed nurse or certified medication aide will be given another medication administration pass competency and must pass the competency in order to work independently. Any newly hired license nurse or newly	

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F 760	Continued From page 44 confirmed that the blood pressure was high at 5:27 AM with a reading of 189/93 mm/hg and it was not signed off as given by Nurse #7. She stated she could not recall if Nurse #7 passed on in report that as needed Clonidine was given due to systolic blood pressure greater than 160 mm at 5:27 AM. An interview with the Physician Assistant on 05/02/24 at 11:10 AM revealed the resident's blood pressure was elevated at 5:27 AM and remained elevated at 10:25 AM. She would have expected the medication to be given at 5:27 AM and if it had, it may not have remained elevated at 10:25 AM. The Physician Assistant stated the medication should have been administered when the nurse noted the blood pressure was 172/88mm/hg. An interview with the Director of Nursing on 05/02/24 at 4:48 PM revealed she would have expected the nursing staff to administer the ordered as needed Clonidine to help with lowering Resident #1's blood pressure. She stated the necessity of blood pressure medication was to lower the blood pressure and the nurses should have administered the medication on 02/15/24. The DON added that documenting whether or a not a medication was given was important because it was your verification that the medication was given. 1b. A review of the physician orders for Resident #3 revealed an order written on 03/01/24 for Enalapril Maleate tablet 20 milligrams give one tablet in the morning for hypertension; hold for systolic blood pressure less than 100, and an order written on 03/22/23 Amlodipine Besylate tablet 5 milligrams give one tablet every 12 hours	F 760	hired certified medication aide will receive the education from the staff development coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in charge on following physician's orders for medication administration on next steps when an antibiotic medication is not readily available prior to medication administration; following physician orders for medication with stop dates and any antihypertensive medications with blood pressure parameters must be followed during their classroom orientation, prior to provision of care. Any agency license nurse or agency certified medication aide will receive the education from the staff development coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in charge, on following physician's orders for medication administration and on next steps when an antibiotic medication is not readily available prior to provision of care; follow physician order for medications with stop dates and any antihypertensive medications with blood pressure parameters must be followed. 4. Four (4) times a week for twelve (12) weeks the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in charge will randomly observe ten residents' medication administration per order or that the physician was notified for further orders. During the auditing, if it is noted that the process was not followed, the licensed nurse or certified medication aide will be removed from patient care and a	

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ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 760	Continued From page 45 for hypertension; hold for systolic blood pressure less than 100. A review of the Medication Administration Record for May 2024 revealed on 05/01/24 Nurse #1 administered the ordered Enalapril 20 milligrams and Amlodipine 5 milligrams at 9:00 AM as evidenced by her nursing initials and a check mark. An interview with Nurse #1 on 05/01/24 at 10:50 AM revealed she did not obtain a blood pressure prior to administering Resident #1's blood pressure medications. Nurse #1 reviewed the current physician orders in the medication administration record and confirmed the order for the blood pressure medications had parameters to hold if the systolic blood pressure was less 100 mm/hg. Nurse #1 stated she did not check the blood pressure before she administered the two medications and she should have per the order. She stated it was important to check the blood pressure before administering blood pressure medications because if her blood pressure was too low and she received the medications it could be dangerous. Nurse #1 reported according to the medical record the last time the blood pressure was taken for Resident #1 was at 3:00 AM on 05/01/24 and it was recorded as 120/63mm/hg. An interview with the Physician Assistant on 05/02/24 at 11:10 AM revealed she would have expected the nursing staff to follow the orders and obtain a blood pressure prior to administering the blood pressure medications. She added, the parameters were in the order for a reason and if the systolic blood pressure was less than 100 the medication should have been held. She stated	F 760	one-to-one inservice will be provided by the Director of Nursing or Staff Development Coordinator. The licensed nurse or certified medication aide will not be permitted to provide patient care until they can correctly state the facility's process for following the physician orders and starting the antibiotic timely. Additionally, twice daily for four (4) weeks, a facility wide audit of the Electronic Medical Records Dashboard will be performed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in charge to assure each resident's antibiotic medication is administered per physician order. The audits will be presented by the Director of Nursing to the facility's QAPI committee will for review for three (3) months. The facility's QAPI committee will make recommendations as needed to assure compliance is sustained ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 46	F 760		

without obtaining the blood pressure prior to administration a resident was at risk for lowering the blood pressure unnecessarily.

An interview with the Director of Nursing on 05/02/43 at 4:48 PM revealed she would expect the nursing staff to follow the physician orders and obtain a blood pressure before administering blood pressure medications if the order indicated parameters to hold the medication. She added, the blood pressures medications were given to manage blood pressures and it was important to know what their blood pressure was before administering. The necessity of the drug was to lower the blood pressure and if a nurse gives a blood pressure medication when your blood pressure was already too low it could affect the resident with a negative outcome.
2). Resident #10 was admitted on 10/23/07 with diagnosis which included in part: heart disease and hypertension.

Review of Resident #10's care plan revealed a focus last revised on 4/18/24 indicated a focus of altered cardiovascular status related to angina (chest pain) and coronary artery disease. Interventions indicated in part administer medications as order and monitor for side effects and effectiveness.

Review of Resident #10's 3/13/24 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact.

Review of Resident #10's physician orders revealed a 4/8/24 order for Isosorbide Dinitrate Oral Tablet 5 milligrams. Give 1 tablet by mouth two times a day for angina. Hold for systolic blood pressure less than100.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 760	Continued From page 47	F 760		

Review of Resident #10's April 2024 Medication Administration Record (MAR) revealed the following entry: Isosorbide Dinitrate Oral Tablet 5 milligrams. Give 1 tablet by mouth two times per day
for Antianginal. Hold for systolic blood pressure less than100. Start date 4/08/2024. The entry did not include an entry for blood pressure monitoring. The MAR indicated the medication Isosorbide Dinitrate was administered daily at 8:30 AM and 8:30 PM.

Review of Resident #10's electronic health record revealed the following blood pressures were recorded:

4/10/2024 5:31 AM 128/87 millimeters of mercury (mm/Hg)
4/12/2024 5:35 AM 132 / 82 mmHg
4/13/2024 4:24 AM 130 / 78 mmHg
4/14/2024 4:18 AM 159 / 77 mmHg
4/15/2024 4:05 AM 148 / 87 mmHg
4/16/2024 4:30 AM 145 / 80 mmHg
4/17/2024 5:34 AM 136 / 78 mmHg
4/18/2024 5:38 AM 128 / 76 mmHg
4/19/2024 6:21 AM 142 / 71 mmHg
4/20/2024 5:24 AM 136 / 76 mmHg

4/21/2024 6:06 AM 137 / 80 mmHg
4/22/2024 6:05 AM 134 / 74 mmHg

4/23/2024 4:41 AM 131 / 87 mmHg
4/24/2024 5:45 AM 136 / 83 mmHg
4/25/2024 5:34 AM 128 / 76 mmHg
4/26/2024 5:19 AM 130 / 72 mmHg
4/27/2024 6:04 AM 142 / 68 mmHg
4/28/2024 5:41 AM 138 / 77 mmHg
4/30/2024 4:00 AM 107 / 61 mmHg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 48	F 760		

Review of a 4/24/24 pharmacy recommendation for nursing follow up indicated Resident #10 had an order to withhold Isosorbide Dinitrate if systolic blood pressure was less than 100. Review of the electronic MAR indicated the blood pressure was not routinely charted prior to medication administration. Recommendation was made to update the electronic MAR to include charting of the blood pressure with each dose of medication.

Review of the May 2024 MAR revealed on 5/2/24 Nurse #2 administered the ordered Isosorbide Dinitrate at 9:00 AM as evidenced by her initials and a check mark.

An interview on 5/2/24 at 10:10 AM with Nurse #2 revealed she administered Resident #10's 9:00 AM medications including Isosorbide Dinitrate. Nurse #2 stated she must have missed the part of the order that indicated to hold the medication if the systolic blood pressure was less than 100.

An interview was conducted on 5/2/24 at 10:30 AM with the Unit Manager. The Unit Manager stated when an order for a medication was entered into the computer, if there was a parameter to hold for a certain blood pressure reading, then the blood pressure monitoring should be linked to the order so that the readings are documented with the administration of the medication. The Unit Manager stated the order for Isosorbide Dinitrate for Resident #10 was entered incorrectly and did not include the required blood pressure monitoring and documentation.

An interview on 5/2/24 at 11:30 AM with the Physician Assistant revealed she expected that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 49	F 760		

the blood pressure would be taken prior to each administration of a medication with a parameter. If the resident received the medication twice per day, the Physician Assistant stated she expected the blood pressure to be checked and documented twice per day. The PA stated it was important to document the blood pressure readings to determine if there was a trend and she would need the complete documentation to evaluate this. She added the parameters were in the order for a reason and if the systolic blood pressure was less than 100 the medication should have been held.

Interview on 5/2/24 at 3:30 PM with the Director of Nursing revealed she expected the nursing staff to follow the physician order and obtain a blood pressure prior to each administration of a medication if the order indicated a parameter to hold the medication.

3.)Resident #91 was admitted to the facility on 01/22/24 with diagnoses including urinary tract infection.

The Minimum Data Set (MDS) quarterly assessment dated 04/26/24 revealed Resident #91 was cognitively intact. He had no rejection of care and received antibiotics.

A care plan dated 04/30/24 revealed Resident #91 had a urinary tract infection and was at risk for complications. Interventions included to administer antibiotic therapy as ordered.

A physicians order dated 04/22/24 for Resident #91 revealed Ciprofloxacin 250 milligrams, give 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 760	Continued From page 50	F 760		

tablet by mouth every 12 hours for Infection for 5 Days.

Review of the Medication Administration Record (MAR) dated April 2024 for Resident #91 revealed Ciprofloxacin 250 milligrams to give 1 tablet by mouth every 12 hours for infection for 5 Days. The medication was scheduled to be administered at 9:00 AM and 9:00 PM. The first dose was scheduled to be given on 04/22/24 at 9:00 PM. The MAR revealed only 7 of the 10 prescribed doses were administered. The MAR revealed the following:

04/22/24 at 9:00 PM the medication was not administered.

04/23/24 at 9:00 AM the medication was signed as administered.

04/23/24 at 9:00 PM the medication was not administered. Code "9" was entered on the MAR which indicated to see nursing notes.

04/24/24 at 9:00 AM the medication was not administered. Code "9" was entered on the MAR which indicated to see nursing notes.

04/24/24 at 9:00 PM the medication was signed as administered.

04/25/24 at 9:00 AM the medication was signed as administered.

04/25/24 at 9:00 PM the medication was signed as administered.

04/26/24 at 9:00 AM the medication was signed as administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 51	F 760		

04/26/24 at 9:00 PM the medication was signed as administered.

04/27/24 at 9:00 AM the medication was signed as administered.

Review of the nursing progress notes for Resident #91 dated 04/23/24 at 9:00 PM and 04/24/24 at 9:00 AM revealed no documentation as to why Ciprofloxacin 250 mgs was not administered.

During an interview on 05/01/24 at 10:00 AM the Physician indicated the full course of antibiotics should have been administered to Resident #91 according to the order. He stated there would be no significant outcome from not receiving the full 10 days of antibiotic treatment. He indicated Resident #91 had improved and had no further concerns.

During an interview on 05/02/24 at 12:42 PM the unit manager stated she was not aware Resident #91 did not receive the full course of Ciprofloxacin. She indicated the missed doses were likely due to the medication not being received from Pharmacy at that time. She reported she had discussed with the Physicians to hold antibiotic orders until the medication was received from Pharmacy so that the administration dates were accurate in order for the resident to get the full course. She stated the dates should have been adjusted on the MAR when the medication was received from Pharmacy to ensure the exact doses were given. She indicated that was not done.

The assigned nurses for Resident #91 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 52	F 760		

04/22/24, 04/23/24, and 04/24/24 were not in the facility during the investigation and unavailable for interview.

During an interview with the Director of Nursing on 05/02/24 at 2:30 PM she stated medication orders should be followed and administered according to the physicians orders. She indicated education would be provided to nursing staff on medication administration.

4.) Resident #401 was admitted to the facility on 04/22/24 with diagnoses that included cellulitis of the left lower limb and history of opioid dependence.

The hospital discharge summary dated 04/22/24 included orders for Resident #401 for Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days.

The hospital discharge summary dated 04/22/24 included orders for Resident #401 for Oxycodone 5 mgs immediate release. Take one tablet by mouth every 4 hours as needed for pain for up to 5 days.

The Minimum Data Set (MDS) admission assessment dated 04/26/24 revealed Resident #401 was cognitively intact.

Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days. Clindamycin was initialed as administered to Resident #401 on the following dates and times which resulted in Resident #401 receiving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 53	F 760		

16 additional doses: The order should have been discontinued after 12 doses.

04/22/24 at 11:00 PM
04/23/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/24/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/25/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/26/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/27/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/28/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/29/24 at 7:00 AM, 3:00 PM, and 11:00 PM
04/30/24 at 7:00 AM, 3:00 PM, and 11:00 PM

Review of the Medication Administration Record (MAR) dated May 2024 revealed Clindamycin was administered to Resident #401 on the following dates and times:

05/01/24 at 7:00 AM, 3:00 PM, and 11:00 PM
05/02/24 at 7:00 AM
Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Oxycodone 5 mgs give 1 tablet by mouth every 4 hours as needed for pain for 4 days. Oxycodone 5 mgs as needed was initialed as administered to Resident #401 on the following dates and times: This order should have been discontinued on 04/26/24.

04/22/24 at 10:43 PM
04/23/24 at 05:21 AM and 01:30 PM.
04/24/24 at 06:24 AM and 08:20 PM.
04/25/24 at 04:14 AM, 09:28 AM, and 03:46 PM.
04/26/24 at 06:22 AM, 01:22 PM, and 08:52 PM.

04/27/24 at 06:33 AM, 01:14 PM and 09:22 PM.
04/28/24 at 08:01AM and 03:34 PM.
04/29/24 at 12:15 AM, 09:36 AM, and 05:14 PM
04/30/24 at 05:50 AM, 10:21 AM, 02:34 AM, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 54	F 760		

06:33 PM.

Review of the Medication Administration Record (MAR) dated May 2024 revealed Oxycodone 5 mgs was administered to Resident #401 on the following dates and times:

05/01/24 at 04:39 AM, 10:52 AM, and 02:25 AM
05/02/24 at 07:00 AM.

During an interview on 05/02/24 at 2:00 PM Nurse #3 acknowledged that she was the nurse that entered the orders from the hospital discharge summary for Resident #401 and indicated she should have entered a date for the Clindamycin to be discontinued after 4 days and entered a date for the Oxycodone to be discontinued after 4 days. Nurse #3 stated that if she did not enter dates for discontinuing the medications for Resident #401's Clindamycin or Oxycodone that it was done in error.

During an interview with Resident #401 on 05/01/24 at 11:00 AM she was observed sitting in her wheelchair in her room. She indicated she had no concerns with receiving her medications. She had no complaints of nausea, vomiting or loose stools.

During an interview on 05/02/24 at 10:30 AM the Physician Assistant stated Resident #401 did not experience any significant outcome from receiving this medication beyond the ordered time period. She stated receiving an antibiotic for a longer period of time could put a resident at risk of an infection such as C-Diff (clostridium difficile - a bacteria that causes infection of the colon which often occurred after using antibiotics). She stated overuse of an opioid could lead to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 55 dependence. During a phone interview on 05/02/24 at 5:00 PM the Consultant Pharmacist stated she had not completed the medication regimen review for Resident #401 at this time. She indicated there would be no significant outcome for receiving extra doses of Clindamycin. She indicated antibiotics could cause infection such as Clostridium Difficile. She stated the additional doses of Oxycodone that Resident #401 should not cause her any adverse outcome. During an interview on 05/02/24 at 4:43 PM the Director of Nursing (DON) stated she was not aware the orders for Resident #401 were not discontinued according to the physicians order. She stated she expected the nursing staff to follow the hospital discharge summary and enter orders correctly. She indicated the nurses or unit managers entered medications into the electronic medical record. She stated the physician would be notified and education would be provided on medication administration.	F 760		
F 812 SS=E	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 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		5/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 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 air dry kitchenware before stacking them in storage and failed to ensure refrigerated meat items stored for use in the reach-in refrigerator for resident sandwiches were dated and sealed. These practices had the potential to affect food quality. Findings included: 1. During initial tour of the kitchen, beginning at 10:30 AM on 04/29/24, 8 of 8 wet tray pans were noted to be stacked on top of one another on a storage rack for use. At 10:30 AM on 04/29/24, the Dietary Manager (DM) stated that several times prior to the survey the dietary staff had been in-serviced on making sure all kitchenware was air dried before stacking it in storage. She reported that stacking pieces of wet kitchenware of top of one another in storage promoted the growth of bacteria which could make residents sick. 2. An observation on 04/29/24 at 10:40 AM of the kitchen's reach in refrigerator, with the DM revealed one bag of 16 ounce sliced sandwich ham, not sealed, or dated and open to air. The	F 812	1.Kitchenware removed from stacking, rewashed, and placed on air-dry by dietary manager on 4/2924. Refrigerated meat items discarded by dietary manger on 4/29/24. 2. All residents have the potential to be affected by the deficient practice. 3. Inservice completed by Nursing Home Administrator with dietary manager on 5/3/24 of not stacking washed/wet kitchenware but air-dry and dating and sealing refrigerated meat items when opened. Inservice of dietary staff by dietary manager on 5/15/24 of not stacking washed/wet kitchenware but air-drying and dating and sealing refrigerated meat items when opened. All new dietary orientees will be inserviced on air drying washed/wet kitchenware and dating/sealing refrigerated meat items when opened. 4. Weekly for twelve (12) weeks the dietary manager will audit washed/wet kitchenware for air drying and refrigerated meat items for dating/sealing when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 57 DM was unable to explain why food stored in the kitchen's reach-in refrigerator was not dated and open to air. During an interview with the DM on 04/29/24 at 10:40 AM she said she monitored the items in the refrigerators and freezers weekly when conducting inventory. She stated the bag of sliced ham should have been dated and sealed and not opened to air to prevent spoilage. During an interview with the Administrator on 04/29/24 at 5:00 PM, she reported it was her expectation the facility's kitchen staff follow all regulatory guidelines for food and kitchen sanitation safety.	F 812	opened for accuracy. The results of the audits will be presented by dietary manager to the monthly QAPI meeting for three (3) months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
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	F 867		5/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 05/02/2024

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F 867	Continued From page 58	F 867		

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.

§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

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F 867	Continued From page 59	F 867		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 60 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: (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 observations, record review and resident, Physician, Physician Assistant, and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification and complaint investigation surveys of 11/19/21 and 1/20/23 and the complaint investigation surveys of 4/21/22, 11/8/22, and 11/20/23. This was for 6 recited deficiencies on the current recertification and complaint investigation survey of 5/2/24 in the areas of: safe, clean, comfortable, and homelike environment (584), resident assessments (F641), bowel/bladder incontinence, catheter care, urinary tract infections (F690), posting of accurate nurse staffing information (F732), medication error rate of 5% or more (759), and significant medication errors (760). The continued failure during two or more surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included:	F 867	1. On 5/20/24 the Regional Vice President of Clinical Services educated the Nursing Home Administrator and Director of Nursing on developing and maintaining an effective Quality Assurance and Performance Improvement Program. August's Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD)and in the development of the plan of correction (POC). 2. Residents residing in the facility have the potential to be affected. 3. On 5/20/24 the Regional Vice President of Operations provided education and training to the Facility Administrator regarding the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 5/20/24, under the	

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F 867	Continued From page 61 This tag is cross referenced to: F584: Based on observations, resident and staff interviews the facility 1a) failed to repair torn floor linoleum in resident rooms (513 and 515), 1b) failed to remove the black greenish substance from the commode base caulking in resident rooms (511, 513, 515, 606, and 608), 1c) failed to repair a broken free standing clothes cabinet doors in resident rooms (510, 513, and 608), 1d) failed to repair leaking commode bases in resident rooms (506, 511, 513, 515, 608, 612, and 615), 1e) failed to replace broken or missing bathroom door threshold strip in resident rooms (500, 510, 612, 613, and 615), 1f) failed to replace broken or missing toilet paper dispensers in resident rooms (612), 1g) failed to repair resident's overhead lights that were either non-functioning, missing a light cover, or had broken light covers in rooms (515 and 601), 1h) failed to replace broken window blinds in resident rooms (515, 606, and 608); and 2a) failed to eliminate a strong urine and feces odor noted on the 500 and strong urine odor on the 600 hall which was also detected in residents' rooms. These failures occurred on 2 of 6 hallways (500 Hall and 600 Hall) observed for a safe, clean, homelike environment. During the 4/21/22 complaint investigation survey, the facility failed to maintain a clean and sanitary environment by mold growing on the wall in room 200. During the 11/8/22 complaint investigation survey, the facility failed to eliminate a strong urine odor noted on the 500 and 600 halls of the facility. During the 1/20/23 recertification and complaint	F 867	direction and supervision of the Regional Vice President of Operations and Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator, Maintenance Director, Staff Development and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. During the QAPI meeting, the committee decided to initiate weekly QAPI meetings to review the status of the Plan of Correction for safe clean, comfortable and homelike environment (F584), resident assessments (F641), bowel/bladder incontinence, catheter care, urinary tract infections (F690), posting of accurate nurse staffing information (F732), medication error rate of 5% or more (F759), and significant medication errors (F760). 4. An AdHoc QAPI meeting was held on 5-8-24 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Maintenance Director, MDS Coordinator, Social Service Director, Business Office Manager, Rehab Service Director, Admissions Director, Regional Vice President of Clinical Services and Regional Vice President of Operations.	

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F 867	Continued From page 62 investigation survey, the facility failed to: repair torn floor linoleum in resident rooms; remove the black greenish substance from the commode base caulking in resident rooms; ensure the ceilings were free from damaged drywall in shower rooms; repair a broken wall cabinet door in resident rooms; replace rough, worn, splintered handrails on the halls; repair leaking commode bases in resident rooms; repair drywall wall damage in resident rooms; replace broken or missing floor tile in resident rooms; and replace broken window blinds in resident rooms. F641: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of respiratory, nutrition and weight loss, unnecessary medications, and communication and sensory (Residents #19. #47, #35, #17 and #1). During the 11/19/21 recertification and complaint investigation survey, the facility failed to accurately code the MDS assessments for activities of daily living and range of motion. During the 1/20/23 recertification and complaint investigation survey, the facility failed to accurately code the MDS assessments accurately in the areas of medication received and falls. F690: Based on observations, record review and staff interviews, the facility failed to use a clean washcloth and clean water to provide catheter care for 1 of 1 resident reviewed for an indwelling urinary catheter (Resident #61).	F 867	The QAPI Committee will meet weekly for twelve (12) weeks beginning on 5-15-24 ongoing, t monitor the implementation of the plan of correction, including the education component and the ongoing audits to evaluate the effectiveness of the plan of the correction and if necessary, provide additional education and request additional audits/reports. Corporate oversight will be provided in the center's QAPI meeting to assist the facility in achieving and maintaining compliance. The Administrator is responsible for ensuring this plan of correction is implemented.	

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F 867	Continued From page 63	F 867		

During the 11/19/21 recertification and complaint investigation survey, the facility failed to: clarify and transcribe an order for a continuous indwelling urinary catheter to include the size of the catheter and orders to maintain and care for the catheter; appropriately perform catheter care and maintain the resident ' s dignity and privacy; and position the indwelling urinary catheter below the level of the bladder to prevent back flow of urine.

F732: Based on record review and staff interview, the facility failed to post accurate nurse staffing information for 18 of 106 days reviewed (October 1, 2023, through April 30, 2024) and failed to complete a Daily Staffing Form on one day (December 25, 2023) for staffing.

During the 1/20/23 recertification and complaint investigation survey, the facility failed to post complete and accurate staffing data and post daily staffing forms and failed to save the daily staffing forms for the regulatory time frame of 18 months.

F759: Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5%. There were 3 medication errors observed out of 25 opportunities which resulted in a medication error rate of 12%. This occurred for 2 of 3 residents reviewed during a medication pass observation. (Resident #401, #84).

During the 1/20/23 recertification and complaint investigation survey the facility failed to maintain a medication error rate of less than 5%.

F760: Based on record review, staff and the

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F 867	Continued From page 64	F 867		

Physician Assistant interviews the facility failed to administer an as needed antihypertensive medication as prescribed by the physician for blood pressure greater than 160 millimeters of mercury (mm Hg) resulting in 2 missed doses (Resident #3) and failed to check a resident's blood pressure prior to administering a scheduled nitrate medication used to treat angina (chest pain) with parameters to hold the medication if systolic (the top number of a blood pressure reading that measures the pressure in the arteries when the heart beats) blood pressure was less than 100 (Resident #10). This occurred for 2 of 2 reviewed for medication administration.

During the 11/8/22 complaint investigation survey, the facility failed to accurately administer medications when a resident was administered medications belonging to another resident which included a blood pressure medication and an antianxiety medication which required the resident to be sent to the Emergency Room for further evaluation.

During the 1/20/23 recertification and complaint investigation survey, the facility failed to administer 14 doses of an antiseizure medication being used to treat schizoaffective disorder.

During the 11/20/23 complaint investigation survey, the facility failed to prevent a significant medication error when a resident was administered the wrong medications resulting in a drug overdose.

An interview was conducted on 5/2/24 at 5:15 PM with the Administrator. The Administrator indicated the leadership changes in the facility led to the QAPI programs not being effectively

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F 867	Continued From page 65 sustained. She further indicated education was needed and a process needed to be implemented to ensure medication errors would not occur. The Administrator stated the facility was actively working on making improvements in the facility to improve the environment.	F 867		