DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		LETED
		345509	B. WING			C 23/2020
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EN		115 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 550	conducted onsite on offsite on 10/21/20 ar resulted in 3 of the 7 substantiated resultin See Event # OBYH11	g in federal deficiencies.	F 550			11/9/20
SS=D	-	-	F 550			11/9/20
	self-determination, an access to persons an	ght to a dignified existence, nd communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				
LABORATORY	, DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					11/09/2020

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

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING _				C 23/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO)DE		
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 550	 §483.10(b)(1) The factor resident can exercise interference, coercion from the facility. §483.10(b)(2) The rest free of interference, correprisal from the facilit rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on observation and residents the facility prevent the bag's comothers for 3 of 3 resid #8) reviewed for urinate Findings included: 1. Resident #8 was and 4/17/2019 with diagnot intervertebral disc dego bladder. The resident's most repaired was cognitive behaviors. Resident #8 had funct and could make his not resident was cognitive behaviors. Resident #0 had and indwelling cat the assessment period. On 10/22/2020 at 9:30 	cility must ensure that the his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this " is not met as evidenced ins and interviews with staff lity failed to maintain dignity inary drainage bags to tents to be viewed by ents (Residents #3, #7, and ary catheter care. dmitted to the facility on oses that included generation and neurogenic ecent quarterly Minimum d 10/21/2020, revealed tional vision and hearing eeds known to others. The ely intact without moods or #8 was reported to require assistance for activities of nal hygiene. The resident theter and ostomy during d.	F 5	F-550 This plan of correction cons written allegation of complia Preparation and submission correction does not constitu admission or agreement by the truth of the facts or alleg correctness of the conclusic on the statement of deficien of correction is prepared an solely because of the requir state and federal law and to the good faith attempts by th improve the quality of life of Root Cause: The Administrator and the D Nursing discussed with the committee team on 11/06/20 the root cause of this allege non-compliance. Root cause conducted revealed that the non-compliance resulted fro training/understanding of the regarding resident rights an	nce. of this plan te an the provide ged, or the ons set forth icies. This p d submitted ement under d demonstration he provider each reside Director of IDT QAPI 020 to ident d e analysis a alleged om inadequa e staff	r of lan er te to ent.	

Facility ID: 970412

If continuation sheet Page 2 of 29

		ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVE 10. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	TIPLE CONSTRUC			E SURVEY IPLETED	
		345509	B. WING			C 10/23/2020		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP COD			
				915 PEE DEE	ROAD			
ACCORDI	US HEALTH AT ABERD	EEN		ABERDEEN	I, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC EACH CORRECTIVE ACTION COSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 550	Continued From pag	e 2	F	550				
		ag hanging under his chair,			drainage bags must a	lwavs have a		
	easily viewed by othe	e was observed in the bag.		-	cover placed over the	•		
		e was observed in the bag.		For affe	cted resident(s):			
	On 10/22/2020 at 9:3	30am an interview was			nts #3, #7, and #8 all h	nad privacy		
	conducted with Resid	dent #8. The resident stated			placed over their urina	· ·		
	-	er on his bag and he would		bags eff	fective 10/22/2020 an	d thereafter.		
		ag. He further stated he has						
		e in the past and would be			er residents with the p	otential to be		
		ne had to see that. Resident		affected		al ta ha		
		ast cover fell off, he was told were no more covers in the			lents have the potenti I by this alleged non-c			
		been ordered. He could not			a result, the systemic			
		conversation took place or			elow have been put i			
		ber told him there were not			any risk of affecting a			
	covers in stock. He s week since he had a	tated it had been at least a cover on his urinary		resident	ts.			
	drainage collection b	ag.			plan to prevent re-occ 6/2020 the Administra			
		:00am an interview was			r of Nursing initiated re			
		nit manager. She stated			aff regarding resident			
		r the urinary drainage			d to have a privacy co	•		
	collection bags in the certain why they wer	e facility and she was not		over all	urinary drainage bags	s at an times.		
		e not being duized.		Facility	plan to monitor its per	formance to		
	On 10/22/2020 11:35	5am an interview was			ure that solutions are			
		e #3. He stated he was			t sheet will be done by			
	assigned to Residen	t #8 from 7:00am until		Adminis	strator, DON, or desig	nee to		
	-	d about a cover for his			and ensure that all re			
		, the Nurse stated he was an			y drainage bag will ha			
		as not sure why Resident #8			iate privacy covering.			
		on his urinary drainage bag if the facility had any for use.			ing process will take p or 3 weeks, weekly for			
	and he was not sufe				on the for 3 months.	J WEEKS,		
	On 10/22/2020 at 1:0	00pm the resident was			and y for 0 monuto.			
	observed seated in h	-		The Adr	ministrator, DON, or d	esignee will		
		r over his urinary drainage			ndings of the monitori			
	collection bag.			to the fa	acility Quality Assuran	ce and		
				Perform	ance Improvement C	ommittee for		

Facility ID: 970412

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/17/2020 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 10/23/2020		
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
400000				9	15 PEE DEE ROAD			
ACCORD	US HEALTH AT ABERDE	EN		A	ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 550	An interview was con the facility administra 2:00pm. Both the DO stated it was their exp privacy covers over u maintain their dignity. 2. Resident #7 was a 11/21/2017 for diagne encephalopathy and Resident #7's most re Set (MDS), dated, 10 resident had function could make her need resident had function could make her need resident had mild cog understand others an Resident #7 was cod assistance with activi personal hygiene. On 10/22/2020 at 9:4 observed in the hall ju had an uncovered uri on the bottom left sid contained urine. Whe she did want a cover collection bag and sh not have one. She co had gone without a co she could not see the under her wheelchair could and she did not her urine. On 10/22/2020 at 11: conducted with the un there were covers for	ducted with the DON and tor on 10/23/2020 at N and the administrator bectation residents have irinary collection bags to dmitted to the facility on bess that included metabolic neurogenic bladder. ecent annual Minimum Data /9/2020, revealed the al hearing and vision and s known to others. The gnitive impairment but could d be understood by others. ed as needing physical ties of daily living and 3am resident #7 was ust outside of her room. She inary catheter bag hanging e of her wheelchair which en asked, the resident stated over her urinary drainage e was not sure why she did buld not state how long she over. The resident stated e bag once it was placed but she knew other people t like that people could see	F	550	any additional monitoring or modifica of this plan. The QAPI Committee ca modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/9/2020.			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE		
		345509	B. WING			C 10/23/2020		
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT ABERDE	EN			915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 550	certain why they were An interview was con 11:40am with the trea assigned to Resident stated she did not kno have a cover on her u NA on the hall would An interview was con 11:42am with NA #6 v assigned to Resident know why the resident her urinary drainage of An interview was con the facility administrat 2:00pm. Both the DO stated it was their exp privacy covers over u maintain their dignity. 3. Resident #3 was an 9/14/2020 with diagno intellectual disability a of the sacrum. The resident's admiss (MDS), dated, 9/12/20 was severely cognitive extensive assistance living and personal hy On 10/20/2020 at 11 observed in her bed w collection bag easily w was not covered and	e not being utilized. ducted on 10/22/2020 at timent nurse who was also #7. The treatment nurse ow why the resident did not urinary collection bag but the know. ducted on 10/22/2020 at who stated she was #7. She stated she did not at did not have a cover on collection bag. ducted with the DON and tor on 10/23/2020 at N and the administrator bectation residents have rinary collection bags to dmitted to the facility on bases that included and stage four pressure ulcer sion Minimum Data Set 020, indicated the resident ely impaired, and required with all activities of daily //giene. 35 am Resident #3 was vith a urinary drainage /isible from the hall. The bag	F	550				

Facility ID: 970412

If continuation sheet Page 5 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE		
AND I LAN OI	CONNECTION	IDENTIFICATION NONIDER.	A. BUILDII	NG _			C	
		345509	B. WING _			10/23/2020		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT ABERDE	EN			15 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 550	10/20/2020 11:00am i attention of the DON a who were conducting resident did not have drainage bag that cou The Director of Nursir get a privacy cover fo bag. On 10/22/2020 at 9:43 revealed the urinary of not have a cover and hall. The resident's dr contain urine. On 10/22/2020 at 11:0 conducted with the ur there were covers for collection bags in the certain why they were An interview was cond 11:40am with the trea assigned to Resident stated she did not kno have a cover on her u NA on the hall would I An interview was cond 11:42am with NA #3 v assigned to Resident know why the resident her urinary drainage of An interview was cond 11:42am by the poly assigned to Resident know why the resident her urinary drainage of An interview was cond the facility administrat 2:00pm. Both the DOI stated it was their exp	it was bought to the and the treatment nurse the wound care, that the a cover on the urinary ild be seen from the hall. ng (DON) stated they would r the resident's drainage 3am a second observation drainage collection bag did was easily visible from the rainage bag was observed to 00am an interview was hit manager. She stated the urinary drainage facility and she was not e not being utilized. ducted on 10/22/2020 at tment nurse who was also #3. The treatment nurse ow why the resident did not urinary collection bag but the know. ducted on 10/22/2020 at vho stated she was #3. She stated she did not it did not have a cover on collection bag. ducted with the DON and tor on 10/23/2020 at N and the administrator vectation residents have rinary collection bags to	F	550				

Facility ID: 970412

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/17/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345509	B. WING_				C 1 23/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT ABERDE	EN		9	15 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	EN		Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)		F	604			11/9/20
	§483.10(e) Respect a The resident has a rig and dignity, including:	ht to be treated with respect					
		estraints imposed for or convenience, and not esident's medical symptoms,					
	 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. 						
	§483.12(a) The facility	y must-					
	from physical or chempurposes of discipline are not required to tressymptoms. When the indicated, the facility r alternative for the lease document ongoing re- restraints.	nust use the least restrictive					
	Based on observation interviews and record prevent a resident fro restrained with a shee	ns, staff and Physician review, the facility failed to m being physically et tied to his wheelchair cility also failed to reassess			F-604 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plar	n of	

Facility ID: 970412

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	CO	MPLETED
		345509	B. WING			С
	ROVIDER OR SUPPLIER	345509	B. WING	STREET ADDRESS, CITY, STATE, ZI		0/23/2020
NAME OF P	ROVIDER OR SUPPLIER			915 PEE DEE ROAD	PCODE	
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 604	Continued From page	o 7	F 60			
1 001		ed of a restraint (pommel	FUU	correction does not cons	tituto on	
	cushion) and attempt			admission or agreement		
		sident #6). This was for 3 of		the truth of the facts or a		
		for restraints. The findings		correctness of the conclu		
	included:	5		on the statement of defic	iencies. This plan	
				of correction is prepared	and submitted	
		admitted on 11/18/19 with a		solely because of the rec	-	
	diagnosis of Alzhimer	r's Disease.		state and federal law and		
	Lis monto de Minsiero			the good faith attempts b		
		ım Data Set (MDS) dated		improve the quality of life	e of each resident.	
	physical behaviors, re	vere cognitive impairment,		Root Cause:		
		S was coded for no falls since		The Administrator and th	e Director of	
	previous assessment			Nursing discussed with the		
		-		committee team on 11/06		
	Resident #5's fall car	e plan dated 9/23/19 read he		the root cause of this alle	-	
	was a high risk for fal	lls due to his confusion and		non-compliance. Root ca	ause analysis	
		ess. The intervention read		conducted revealed that		
	increased staff monit	oring.		non-compliance resulted	-	
				training/understanding of		
		t note dated 10/12/20 at		regarding the proper pro		
		ent #5 was noted sitting at a room with a sheet tied		usage, the continued nee		
		vaist to the wheelchair.		with supporting documer attempt of a restraint red		
	-	t and answering questions				
		pain or discomfort. The sheet		For affected resident(s):		
		was no redness and his		Resident #5 had the she	et removed by	
	abdomen was soft ar	nd non-tender.		the unit manager upon d	iscovery on	
	Boviow of Booidant +	te's bobaviors care plan		10/12/2020. Resident #4		
		#5's behaviors care plan behaviors care plan read he		reassessment and reduct 10/28/2020. Resident #6	-	
		less, verbal and physicial		reassessment reduction		
		ers and a behavior of		10/27/2020.		
		d the locked unit. The care				
		10/13/20 read he repeatedly		For other residents with t	the potential to be	
	-	the wheelchair, would go		affected:		
		armrest and was a high fall		All residents have the po		
		cluded staff intervening as		affected by this alleged n		
	necessary to protect	the rights and safety of		and as a result, the syste	emic changes	

Facility ID: 970412

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 093	8-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVE COMPLETED	
					С	
		345509	B. WING	·····	10/23/20	20
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ACCORDI	US HEALTH AT ABERDE	EN		915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE COM THE APPROPRIATE	(X5) PLETIO DATE
F 604	Continued From page	e 8	F 60)4		
		n, remove from the situation		stated below have been p prevent any risk of affecti residents.		
	dated 10/16/20 subm read as follows: the a unsubstantiated. On t aide coming in of first #5 had a sheet aroun wheelchair. The aide the sheet was remove	s 5-day Investigation Report itted to the state agency illegation of abuse was the morning of 10/12/20, the t shift discovered Resident id his waist and tied to his alerted management and ed. He had the ability to thair and get to his body. He		Facility plan to prevent re On 11/6/2020 the Adminis DON initiated re-educatio staff regarding the proper restraint use that includes restraint reassessment ar attempt along with suppo documentation.	strator and the n to the nursing process for s the need for a nd reduction	
	physical or emotional at his baseline physic mentally. At the cond investigation, it was d			On 11/6/2020 the Adminis DON initiated re-educatio staff regarding the need f coding on the MDS to ref restraint.	n to the MDS or accurate	
	The facility's investigated determine the respondegree of certainly bunching Assistant (NA of the investigation. Nareturn to work after the termine the termine the termine the termine termin	ation was also unable to usible person with any ut suspended Nurse #1 and A) #2 pending the conclusion Nurse #1 was allowed to he investigation but NA #2 and did not return to work at		Facility plan to monitor its make sure that solutions An audit sheet will be dor Administrator, DON, or de monitor and ensure that a free from unnecessary re accuracy of MDS coding	are sustained: he by the esignee to all residents are straints,	
	department who resp Resident #5's Respon notified on 10/12/20 a provided evidence of staff interviews on 10	y contacted the police onded onsite on 10/12/20. nsible Party (RP) was at 11:36 AM. The facility their investigation to include /11/20 on second shift 10/12/20. The facility's root		along with supporting doc that a restraint reassess reduction has been attem quarterly. This monitoring take place daily (M-F) for for 3 weeks, then monthly	nent and pted at least process will 3 weeks, weekly	
	cause anaylisis deter education on techniq resident safe. Correc immediate re-educati restraints and technic	mined the staff required ues regarding how to keep a tive action included		The Administrator, DON, report findings of the mor to the facility Quality Assu Performance Improvement any additional monitoring of this plan. The QAPI Co	itoring process irance and nt Committee for or modification	

Facility ID: 970412

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	MEDICAID SERVICES				IO. 0938-039
		. ,		· · · ·	TE SURVEY MPLETED
		A. BUILDING	G		
	245500	B WING			С
	345509	B. WING			0/23/2020
ROVIDER OR SUPPLIER				PCODE	
US HEALTH AT ABERDE	EEN				
			ABERDEEN, NC 28315		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
Continued From page	_ 0	F 60			
		FUC	-	o the facility	
of staff re-edication o	n abuse and restraints and				
-				lianaa an	
•				mance on	
			11/9/2020.		
Investigation report	were submitted timely.				
A telephone interview	was conducted with Nurse				
worked the 11-7 shift	on 10/12/20. She recalled				
giving report to Nurse	e #2 on 10/12/20 and then				
left work. She stated	when she got home, the				
facility called to ask h	er why Resident #5 was tied				
	•				
-					
	•				
	· •				
was unable to walk a	nd he had fallen numerous				
-	-				
-					
-	out he was easiliy arroused. ot notice a sheet tied around				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page the facility's corrective of staff re-edication of evidence the facility to on NA #2 and reporte Care Registry. The 2 Investigation Report of A telephone interview #1 on 10/21/20 at 1:1 worked the 11-7 shift giving report to Nurse left work. She stated facility called to ask h into his wheelchair w she had no idea that him. She recalled eal Resident #5 was sittii wheelchair. Nurse #1 slept at night and was She stated at the beg #5 was constantly sta wheelchair and attern she recalled medicati dose of Lorazepam (a shift. Nurse #1 stated seldom effective and She recalled assisting Resident #5 up in his 1:00 AM she thought was unable to walk a times. Nurse #1 stated observation to prever injuring himself but st concerns to Unit Mar of Nursing (DON). Nu Resident #5's his me while he was sitting in recalled him dozing b	CORRECTION IDENTIFICATION NUMBER: 345509 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 the facility's corrective action revealed evidence of staff re-edication on abuse and restraints and evidence the facility terminaited the employement on NA #2 and reported the incident to the Health Care Registry. The 24 Initial Report and 5-day Investigation Report were submitted timely. A telephone interview was conducted with Nurse #1 on 10/21/20 at 1:17 PM. She stated that she worked the 11-7 shift on 10/12/20. She recalled giving report to Nurse #2 on 10/12/20 and then left work. She stated when she got home, the facility called to ask her why Resident #5 was tied into his wheelchair with a sheet. Nurse #1 stated she had no idea that he had a sheet tied around him. She recalled ealier on the 11-7 shift, Resident #5 was sitting in the common area in his wheelchair. Nurse #1 stated Resident #5 seldom slept at night and was up and down frequently. She stated at the beginning of the shift, Resident #5 was constantly standing up from his wheelchair and attempting to walk. She stated she recalled medicating him with a sa needed dose of Lorazepam (antianxiety) gel early in the shift. Nurse #1 stated his Lorazepam gel was seldom effective and Physician #1 was aware. She recalled assisting NA #2 with pulling Resident #5 up in his wheelchair sometime after 1:00 AM she thought but not sure. She stated he was unable to walk and he had fallen numerous times. Nurse #1 stated Resident #5 needed 1:1 observation to prevent him from falling and injuring himself but she did not report her concorns to Unit Manager (UM) #1 or the Director of Nursi	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345509 B. WING	CORRECTION DENTIFICATION NUMBER: A. BUILDING 345509 B. WING SOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZI US HEALTH AT ABERDEEN STREET ADDRESS, CITY, STATE, ZI SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY WISTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 9 ID the facility's corrective action revealed evidence of staff re-edication on abuse and restraints and evidence the facility terminalied the employement on NA #2 and reported the heighth Care Registry. The 24 Initial Report and 5-day Investigation Report were submitted timely. F 604 A telephone interview was conducted with Nurse #1 on 10/21/20 at 1:17 PM. She stated that she worked the 11-7 shift on 10/12/20. She recalled giving report to Nurse #2 on 10/12/20 and then left work. She stated when she got home, the facility called to ask her why Resident #5 was tied into his wheelchair with a sheet. Nurse #1 stated she had no ide at hat he had a sheet tied around him. She recalled ealier on the 11-7 shift, Resident #5 was sonsting standing up from his wheelchair with a sup and down frequently. She stated when bag of homes is the facility called to sak mown frequently. She recalled medicating him with a as needed dose of Lorazepam (antianxiety) gel early in the shift. Nurse #1 stated his Lorazepam gel was seldom effective and Physician #1 was aware. She recalled medicating him with a as needed dose of Lorazepam (ILM) #1 or the Director of Nursing (DON). Nurse #1 recalled giving Resident #5's his medications around 5-45 AM while he was sitting in the common area. She recalled thi	CORRECTION IDENTIFICATION NUMBER: A BUILDING CONTRACT 345509 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE VONDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2IP CODE IS PEEDEE ROAD AREFNEEN, NC 23315 SUMMARY STREMENT OF DEFICIENCIES ID PREVIDERS PLAN OF CORRECTION (EACH ORACETIVE ACTION SUPPLICE REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 9 ID PREFIX TAG Continued From page 9 ID PREFIX PREFIX Investigation Report were submitted timenly. TAG modify this plan to ensure the facility remains in substantial compliance. A telephone interview was conducted with Nurse #1 on 10/21/20 at 1:17 PM. She stated that she worked the 17-shift on 10/12/20. and then left work. She stated when she got home, the facility called to ask her why Resident #5 was tied into his wheelchair with a sheet. Nurse #1 stated she had no ide at that had a sheet to around him. She recalled regioning of the shift, Resident #5 was constantly standing up from his wheelchair and was up and down frequently. She stated when she got home, the facility called to ask her why Resident #5 was tied into his wheelchair with a sheet. Nurse #1 stated she had no ide was sitting in the common area in his wheelchair and was up and down frequently. She stated at the beginning of the shift, Resident #5 was constantly standing up from his wheelchair and was up and down frequently. She stated this Lorazepam (aniaxinyity) gel early in the shift. Nurse #1 state

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345509	B. WING	G C 10/23/2020					
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-			
ACCORD	US HEALTH AT ABERDE	EN			915 PEE DEE ROAD ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 604	his waist. She stated have happened some NA #2, NA #1 and NA on the night of 10/12/2 an agency aide and s unit a few times. She worked for the facility locked unit for "along was unsure who was night of 10/12/20 bec together to care for ev was suspended and t on abuse and restrain A telephone interview on 10/21/20 at 1:27 P longer worked at the f employee. She stated 11-7 in the locked unis she asked NA #3 wha her to take and NA # work together but stat Resident #5. She state Resident #5 at the be helped pull him up in #1 but was unsure of not tie Resident #5 im sheet. She stated Res attempting to get up of trying to walk when sh NA #2 stated she did 10/12/20 because she assignment but NA #3 A telephone interview on 10/21/20 at 2:24 P 11-7 shift in the locked	to her knowledge, it may etime after that. She stated  were working with her 20. She stated NA #2 was he only worked in the locked stated NA #1 and NA #3 and had worked in the time". Nurse #1 stated she assigned Resident #5 the cause the aides liked to work veryone. She confirmed she he facility re-educated staff its. • was conducted with NA #2 M. She confirmed she no facility and was an agency a she was assigned to work t on 10/12/20. NA #2 stated at assignment she wanted 3 stated she preferred to ted NA #3 was assigned ted she helped NA #3 toilet ginning of the 11-7 shift and his wheelchair with Nurse time. NA #2 stated she did to his wheelchair with a sident #5 was constantly out of his wheelchair and ne worked in the locked unit. not chart on anyone on	F	604					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/17/2020 APPROVED D: 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345509	B. WING			_	C 10/23/2020		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
ACCORDI	US HEALTH AT ABERDE	EN		9	15 PEE DEE ROAD				
				Α	BERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
TAG F 604	Continued From page recalled seeing Resid wheelchair at a table the nursing station wh was not uncommon for sleep in his bed prefe area and nap. NA #1 attempting to stand up wheelchair several tim shift on 10/12/20. He were watching Resid frequently got up and unsafe and had exper A telephone interview on 10/21/20 at 2:28 P worked at the facility f #5 was on her assign stated she often assis floor with their incontin quiet on the locked un beginning of the 11-7 assisted her with toile if he was toileted at th would not need to go the morning. She stat she tried to put him to put Resident #5 into F him to the common are insomnia and did not rather dozed while sit the common area. Sh around midnight, she going to assist the stat their incontinence rou #5 was the only reside	e 11 ent #5 sitting in his in the common area near nen he came in. He said it or Resident #5 to refuse to rring to sit in the common recalled seeing Resident #5 o and sit back down in his nes in the earlier part of the stated NA #2 and NA #3 ent #5 because he attempted to walk but was rienced numerous falls. was conducted with NA #3 M. She stated she had for 10 years and Resident ement on 10/12/20. She sted the staff on the main nence rounds if things were hit. NA #3 stated at the shift on 10/12/20, NA #2 ting Resident #5. She stated he beginning of the shift, he to the bathroom again until ed it was at this time when bed but he refused so she his wheelchair and wheeled rea. NA #3 stated he had sleep much at night but ting up in his wheelchair in he recalled on 10/12/20 told Nurse #1 she was aff on the main floor with nds. She stated Resident ent still up and NA #2		604					
	was walking up the ha	She recalled that as she all to exit the locked unit ething and looked around to #2 trying to prevent							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345509	B. WING				C / 23/2020
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · ·	
				9	915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	EN			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 604	the common area. Na 12:30 am or 1:00 AM locked unit and saw F wheelchair in the cor sheet tied around him again to put Resident knew him and he wou she left work, she got who told her about the She stated she called knew anything about responded by saying did not see Resident i anytime after she retu assisting up front.	ing out of his wheelchair in A #3 stated it was around when she returned to the Resident #5 sitting up in his nmon area and never saw a h. She stated she did not try #5 in bed because she uld not do it. She stated after a text from a co-worker e sheet round Resident #5. I NA #2 and asked her if she the sheet and NA #2 "Oh ****". She stated she #5 attempting to get up urned to the unit from	F	604			
	#5's waist to his whee he was sitting in the of high ¼ wall near the of She stated his wheeld and he was awake. S the nurses station for stated the sheet was She stated Nurse #2 stated after the sheet Resident #5 with his a (ADLs). NA #4 stated saturated and he was stated Resident #5 was assistance often. She abuse and restraints. normal practice to tie She stated she worke	heet tied around Resident elchair on 10/12/20. She said common area near the waist end of the common area. chair brakes were unlocked he recalled pushing him to Nurse #2 to see. She not visable from the front. notified the DON. She was removed, she assisted activites of daily living his brief was wet but not coorpertive with her. She as combative and resisited confirmed re-eucation on NA #4 stated it was never a sheet around a resident. ed with Resident #5 daily on not noticed any evidence of					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345509	B. WING				C /23/2020
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT ABERDE	EN			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 604	result of the incident. A telephone interview #2 on 10/21/20 at 4:2 worked first shift on 7 #1. She stated Nurse Resident #5. Nurse # #1 left, NA #4 brough station and asked her NA #4 then turned his the sheet tied to his w noted his shirt was pu unless you turned him the sheet. She sent f #1 and the (DON). Nur removed the sheet ar injuries such as brush attempted to assess f there was evidence of changes as a result of his poor cognition, it w stated she continued physical, mental and reminder of first shift changes. An interview was con 10/22/20 at 9:20 AM. being followed by psy behavior of standing of trying to walk started stated he had COVID behaviors seemed to was at that time the th the Lorazepam gel. T telehealth visit on 9/2 She stated on the mo	notional adverse effects as a was conducted with Nurse 4 PM. She stated she 10/12/20 and relieved Nurse #1 did not say much about #2 stated shortly after Nurse t him up to the nurses if she saw anything unusal. wheelchair around and saw wheelchair. She looked and ulled down in front and n around, you would not see NA #4 up to front to get UM urse #2 stated UM #1 nd assessed him for any ng and red marks. The DON his mental status to see if f emotional or mental f being restrained but due to was difficult to assess. She to montitor Resident #5's emotional status the and did not note any ducted with UM #1 on She stated Resident #5 was rchiatric services and his up from his wheelchair and in the last few months. She in the last few months. She have worsened after that. It have worsened after that. It have worsened after that. It have worders. rning of 10/12/20, Nurse #2	F	604			
		orning of 10/12/20, Nurse #2 ed unit. She stated when					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345509	B. WING				C 23/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	EN			ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 604	sheet unless he was t she got the DON and completed a physical unable to assess his p his advanced Alzheim Nurse #1 and NA #2 suspicions related to to Resident #5's whee knot tied in the sheet elaborate on what this Resident #5 was a ver required 1:1 observat because of his behav get up and walk but h do so anymore. UM # his RP were both noti stated Resident #5's n his behaviors were "h but it took awhile for t effect. UM #1 stated s Resident #5 into his w for convienience but prevent him from fallin stated his RP was not was fine with if they n #5. She stated she ex staff would not be doi that it happened. An observation of Res 10/22/20 at 9:35 AM. his wheelchair at a tal appeared to be sleep His cognition was ver observed physical inju	ht #5, she could not see the turned around. She stated they removed the sheet and assessment but were psychological status due to her's Disease. UM #1 stated were suspended due to the way the sheet was tied elchair. She described the as "old school" but did not is meant. She stated ery difficult resident and he ion while he was awake ior of continously trying to e was unable to phsycially #1 stated Physician #1 and fied of the incident. She medications precribed for it or miss" and they worked he medications to take she did not think anyone tied wheelchair to punish him or rather out of despiration to ng and injuring himself. She t upset at all and stated it eeded for restrain Resident cplained to the RP that the ng that and it was wrong sident #5 was conducted on He was observed sitting in ble in the common area. He ing but was easliy aroused. y impaired. There was no uries and surveyor unable to I or emotional adverse	F	604	4		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345509	B. WING				C / 23/2020
NAME OF P	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
ACCORD	US HEALTH AT ABERDE	EN			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	Continued From page	9 15	F	604	L L		
	 #1 stated Resident #5 falling with possible in multiple falls while at Resident #5 started e behaviors in August w COVID-19. She state a lot with the COVID- tired and the facility h staff. Physician #1 state applied the sheet to F disperation. She state observation at all time behavior to attempting wheelchair. She state been placed around F wheelchair and the st different option but she in the action. A telephone interview Adminstrator and DO The Adminstirator stat the investigation and they became aware o Resident #5. He state concrete evidence as suspended the Nurse outcome of the invest would confess and the statements. The Adm substantiate the abus there were a lot of ove been through a recen stated he in no way fe into his wheelchair to 	2/20 at 3:23 PM. Physician 5 was a very high risk for hjury and had experienced the facility. She stated xhibiting an increase in when he was diagnosed with d the staff had been through 19 outbreak, the staff were ad been using transiant ated she felt someone Resident #5 out of ed he required close es due to his repeated g to ambulate from his ed the sheet should not have Resident #5 and tied to his aff should have tried a he felt there was no maliace was conducted with the N on 10/23/20 at 2:00 PM. ted they immediately started gathered interviews when of the incident involving ed there was never any					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· <i>`</i>			· /	LETED
						(C
		345509	B. WING			10/	23/2020
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EN			915 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
		,			DEFICIENCY)		
F 604	Continued From page		F	604	1		
	attempting to get out						
		te. The Administrator and eir expectation that other					
		npted with Resident #5 and					
		y's expectation that staff					
		traint such as a sheet to					
	prevent Resident #5 f	rom falling.					
	2. Resident #4 was a	dmitted on 4/4/17 with a					
		Vascular Accident (CVA).					
		I record revealed a consent					
	for a pommel cushion	ent was dated 5/27/20.					
	p = =						
		an dated 5/27/20 read she					
		aint of the pommel cushion.					
		d a valid consent prior to nd ongoing evaluation of					
		It for continued use, risk					
	versus benefits and a	Iternatives to her restraint.					
	Deview of Desident #	1's most recent Dhysical					
		4's most recent Physical Treatment dated 7/30/20					
		s referred by nursing due to					
		ctional mobility and strength.					
		t include any documentation					
	regarding the use of h	her pommel cushion.					
	Review of a Therapy	Referral Form dated 8/13/20					
	read Resident #4 requ	uired the continued use					
	•	out did not include any					
	documentation regard continued use of the						
	Review of Resident #	4's Physician orders					
		ed 8/13/20 for a pommel					
	cushion for positioning posture.	g and to facilitate an upright					
	posicie.						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/17/2020 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING			_		C 23/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EN			15 PEE DEE ROAD BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From page	e 17	F	604				
		/inimum Data Set (MDS) include any indication of the						
	include any evidence or an attempt for a les	4's electronic medical 1/20 to present did not of a restraint reassessment sser restrictive device being nmel cushion being utilized.						
	was still in bed. In her cushion. Nursing Assi Resident #4 had the p could remember and remove the pommel of seated in her wheelch knowledge, the pomm positioning and did no access to her body. S any recent falls. An interview was com (UM) #1 on 10/22/20	20 at 9:15 AM. Resident #4 wheelchair was a pommel istant (NA) #5 stated bommel as long as she Resident #4 was unable to cushion when she was hair. NA #5 stated to her hel cushion was for bt restrict her movement or whe stated was not aware of ducted with Unit Manager at 9:20 AM. She stated the						
	with the last one being was unable to provide regarding the failed re UM #1 stated the pro- reassessment was as gave her and the othe MDS assessments ar reassessments to the stated it was the expe	estraint reduction attempts. cess for the restraint follows: The MDS Nurse er UM a list of upcoming nd then she assigned all the 3rd shift floor nurses. She ectation that a restraint npleted quarterly with an						

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		ND HUMAN SERVICES			FOF	ED: 11/17/2020 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY MPLETED
		345509	B. WING		1	0/23/2020
NAME OF P	ROVIDER OR SUPPLIER	•	- · · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP C		
				915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 604	10:30 AM. She confir documented evidence attempt but stated the pommel cushion was Referral Form dated on Resident #4's read stated the facility cha 2019 and she lost the Resident #4. The RM discussed in the more there was no referral for the continued nee cushion. An interview was con on 10/22/20 at 10:38 the 3rd shift nurses to assessments to inclu She stated she gave advance and the UM shift nurses to complet MDS Nurse stated sh were completed when and it was her unders	ducted with the ler (RM) on 10/22/20 at med she had no e of a restraint reduction e continued need for the documeted on a Therapy 8/13/20 that was completed dmission on 7/29/20. She nged in owership October e previous documentation on I stated the resident's were ning stand up meetings and made to therapy to reassess ed of Resident #4's pommel	F 60		Υ)	
	were completed and were communicated MDS Nurse stated sh could physically remo- from her wheelchair a for positioning. She s did not restrict Reside she was unable to se	ed she was ultimately e the restraint assessments restraint reduction reminders to the UM's and RM. The he did not think Resident #4 oved the pommel cushion and the cushion was needed tated the pommel cushion ent #4's movement because off propel the wheelchair. The he did not think the pommel				

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	-	D HUMAN SERVICES				FORM	APPROVED	
							0.0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	LETED	
						с		
		345509	B. WING				23/2020	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDI	US HEALTH AT ABERDE	FN		9	915 PEE DEE ROAD			
				1	ABERDEEN, NC 28315			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	=	(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE	
			_		DEFICIENCY)			
E 004		40	_					
F 604	15	9 19	F	604	4			
	body.							
	An telephone intervie	w was conducted on						
		with the Adminsitrator and						
		g. Both stated it was their						
		traint reassessment and a empt be completed quarterly						
		a was provided with the least						
	restrictive device and	•						
	3. Resident #6 was a	dmitted on 1/14/17 with a						
	diagnosis of Dementia							
	Review of Resident #	6's physical restraint care						
		d on 10/16/19 read she						
		pommel cushion while up in						
		sitioning. There was only						
	one intervention still a	solved. The intervention						
	read to ensure Reside							
	correctly with proper l	•						
		6's most recent Physical nd Plan of Treatment dated						
		t #6 was referred by nursing						
		her functional mobility and						
	-	ion read Resident #6 had no						
		and the only mention of the						
		listed as prior equipment change in functional ability.						
		ly Minimum Data Set dated						
		e any indication of the use						
	of a restraint.							
	Review of Resident #	6's medical record did not						
	include any orders for	a pommel cushion until						
	10/22/20 when the fac							
	consent from Resider	nt #6's Responsible Party						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			C
		345509	B. WING				23/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EN			15 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From page (RP). Review of Resident # record (EMR) from 1/ include any evidence or an attempt for a les attempted for the por An interview was con (UM) #1 on 10/22/20 was unable to provide regarding a failed rest #1 stated the process reassessment was as gave her and the othe MDS assessments an reassessments to the stated it was the expe	6's electronic medical 1/20 to present did not of a restraint reassessment eser restrictive device being mel cushion being utilized. ducted with Unit Manager at 9:15 AM. She stated she e any documentation traint reduction attempt. UM for the restraint follows: The MDS Nurse er UM a list of upcoming nd then she assigned all the 3rd shift floor nurses. She ectation that a restraint npleted quarterly with an		604			
	was still in bed. In her cushion. Nursing Assi Resident #6 had the p time and used it daily wheelchair. She state recent falls. NA #4 sta pommel cushion was restrict her movemen stated was not aware An interview was con- Rehabilitation Manag 10:30 AM. She stated evidence of a restrain screening for Resider	20 at 9:30 AM. Resident #6 wheelchair was a pommel istant (NA) #4 stated bommel cushion for a long when seated in her ed was not aware of any ated to her knowledge, the for positioning and did not t or access to her body. She of any recent falls. ducted with the er (RM) on 10/22/20 at I she was unable to find any					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345509	B. WING				C 23/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT ABERDE	EN			15 PEE DEE ROAD IBERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 604	2019 and she lost the Resident #6. She con documented evidence attempt for Resident a residents were discus up meetings and ther therapy to reassess for Resident #6's pomme An interview was con on 10/22/20 at 10:38 the 3rd shift nurses to assessments to inclue She stated she gave advance and the UM' shift nurses to comple MDS Nurse stated she were completed wher and it was her unders audited the assessme The MDS Nurse state responsible to ensure were completed and reminders were completed and reminders w	e previous documentation on firmed she had no e of a restraint reduction #6. The RM stated the seed in the morning stand e was no referral made to or the continued need for el cushion. ducted with the MDS Nurse AM. She stated it was up to o do all the quarterly de the restraint assessment. the UM's a list 3 months in s gave the list to the 3rd eted the assessments. The e verified the assessments n she completed the MDS standing that the UM's ents for completion as well. ed she was ultimately the restraint assessments restriant reduction nunicated to the UM's and e stated she did not think ysically removed the her wheelcahir and the for positioning. She stated did not restrict Resident #4's he was unable to self propel MDS Nurse stated she did cushion restricted Resident r body.	F	604			

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				OMB NC	APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				LETED
		345509	B. WING_				C 23/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT ABERDE	EEN			5 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE
F 604	1.0	6 was provided with the least	F	604			
F 641 SS=D	Accuracy of Assessm		F	541			11/9/20
	resident's status. This REQUIREMENT by: Based on observatio record review, the fac Minimum Data Set (N of restraints (Residen nutrition (Resident #3 residents reviewed for finding included: 1. Resident #4 was a diagnosis of Cerebral Resident #4's medica for a pommel cushion positioning. The cons Resident #4's care pl used a physical restra Review of a Therapy read she required the cushion. The referral documentation regard need of the pommel of Review of Resident # included an order dat	st accurately reflect the T is not met as evidenced ons, staff interviews and cility failed to code the MDS) accurately in the areas at #4 and Resident #6) and B). This was for 3 of 9 or MDS accuracy. The dmitted on 4/4/17 with a I Vascular Accident (CVA). al record revealed a consent in with the indication of sent was dated 5/27/20. an dated 5/27/20 read she aint of the pommel cushion. Referral Form dated 8/13/20 e continued use pommel form did not have any ding the rationale for the cushion.			F-641 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provider the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This p of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrat the good faith attempts by the provider improve the quality of life of each reside Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 11/06/2020 to identit the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequat training/understanding of the MDS staff accurately code restraints and (nutrition weight loss.	r of lan er te to ent. ify	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	IG		IPLETED
		345509	B. WING _		1	C 0/23/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERD	EEN		ABERDEEN, NC 28315		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 641	Continued From pag	e 23	F 6	41		
				For affected resident(s):		
	Resident #4's 5-dav	Minimum Data Set (MDS)		Resident #4s MDS for resi	raint use was	
		t include any indication of the		corrected on 10/27/2020.		
	use of a restraint.	,		MDS for restraint use was		
				10/27/2020. Resident #3s		
	An observation and s	staff interview were 20 at 9:15 AM. Resident #4		loss was corrected on 11/6	6/2020.	
		er wheelchair was a pommel		For other residents with th	e notential to be	
		sistant (NA) #5 stated		affected:		
		pommel as long as she		All residents have the pote	ential to be	
		Resident #4 was unable to		affected by this alleged no		
		cushion from her wheelchair.		and as a result, the system	•	
	-	knowledge, the pommel		stated below have been pu	-	
		tioning and did not restrict		prevent any risk of affectin	•	
		cess to her body. She stated		residents.	5	
	was not aware of any	-				
				A 100% audit was complet		
		nducted on 10/22/20 at 10:38		11/9/2020 by the MDS coo		
		irse. She confirmed she		ensure that all restraints a		
		(restraints) of the MDS		were accurately coded on		
		stated the of a pommel		other inaccuracies were id	entified.	
		oded for when Resident #4				
	-	e MDS Nurse stated she did		Facility plan to prevent re-		
		4 could physically removed		On 11/6/2020 the Administ DON initiated re-education		
		from her wheelcahir and the for positioning. She stated		staff regarding the need fo		
		did not restrict Resident #4's		coding on the MDS to refle		
	-	she was unable to self propel		restraints and (nutrition) w		
		MDS Nurse stated she did			eight 1035.	
		I cushion restricted Resident		Facility plan to monitor its	performance to	
	#4 from access to he			make sure that solutions a		
		5		An audit sheet will be done		
	An telephone intervie	ew was conducted on		Administrator, DON, or de	•	
		with the Adminsitrator and		monitor and ensure that al	-	
	the Director of Nursir	ng. Both stated Resident #4's		a restraint and weight loss		
		en coded accurately in the		nutritional concerns are co		
	area of restraints.	-		on the MDS. This monitori	•	
				take place daily (M-F) for 3		
	2 Posidont #6 was a	admitted on 1/14/17 with a		for 3 weeks, then monthly	•	

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	-	D HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		345509	B. WING _	B. WING			C 1 23/2020	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT ABERDE	EN		915 PEE DEE ROAD ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SHOULD BE COMP		
F 641	plan dated last revise required the use of a her wheelchair for pos Resident #6's quarter 7/22/20 did not includ of a restraint. Review of Resident # include any orders for 10/22/20. An observation and s on 10/22/20 at 9:30 A bed. In her wheelchai Nursing Assistant (NA had the pommel cush stated was not aware stated to her knowled was for positioning ar movement or access not aware of any rece An interview was con AM with the MDS Nur completed section P dated 7/22/20. She st should have been coo was up in a chair. The not think Resident #6 the pommel cushion of cushion was needed the pommel cushion of movement because s the wheelchair. The M	a. 6's physical restraint care d on 10/16/19 read she pommel cushion while up in sitioning. ly Minimum Data Set dated e any indication of the use 6's medical record did not r a pommel cushion until taff interview was conducted M. Resident #6 was still in r was a pommel cushion. A) #4 stated Resident #6 ion for a long time. She of any recent falls. NA #4 ge, the pommel cushion ad did not restrict her to her body. She stated was	F	541	The Administrator, DON, or designee report findings of the monitoring proce to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modificati of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/9/2020.	ess e for on		

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	-	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 10/23/2020			
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
ACCORDI	US HEALTH AT ABERDE	EN		915 PEE DEE ROAD ABERDEEN, NC 28315					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 641	the Director of Nursin MDS should have bee area of restraints. 3. Resident #3 was an stage 4 pressure ulce Review of Resident # Data Set (MDS) dated of 187 pounds. She w prescribed weight loss (nutrition) of the MDS by the Dietary Manag Review of Resident # 182.4 pounds. Review of Resident # included orders for a times daily, fortified for assistance with all me An observation and s on 10/20/20 at 12:20 #6 was observed feed She stated Resident # was now required tota eating. She stated Resident diet with supplements An interview was com AM with the MDS Nur responsible for coding	r body. w was conducted on with the Adminsitrator and g. Both stated Resident #6's en coded accurately in the dmitted on 9/4/20 with a er to her sacrum. 3's admission Minimum d 9/12/20 indicated a weight vas coded as being on a s regime at section K 5. Section K was completed er (DM). 3's weight on 9/12/20 was 3's October 2020 orders house supplement three bods and 1:1 eating eals. taff interview was conducted PM. Nursing Assistant (NA) ding Resident #6 her lunch. #6 was losing weight and al staff assistance with esident #6 was on a fortified	F	64					

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	-	ID HUMAN SERVICES				FORM	MAPPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		B. WING			C 10/23/2020		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EN		915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 641 F 686 SS=D	10:57AM with the DM that Resident #3 had weight loss. He stated dated 9/12/20 for a pr was a mistake. An telephone intervier 10/23/20 at 2:00 PM the Director of Nursin MDS should have bee area of nutrition. Treatment/Svcs to Pr CFR(s): 483.25(b)(1)(§483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indiv demonstrates that the (ii) A resident with pre	ducted on 10/22/20 at . He stated he was aware experienced a significant d coding Resident #3's MDS rescribed weight loss regime w was conducted on with the Adminsitrator and g. Both stated Resident #3's en coded accurately in the event/Heal Pressure Ulcer (i)(ii) rity re ulcers. hensive assessment of a hust ensure that- is care, consistent with is of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent	RMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) C0 at F 641 C0 at s aware inficant #3's MDS poss regime on on ador and ator and sident #3's selv in the F 686 ent of a with revent ressure ndition be; and bites sistent			11/9/20	
	promote healing, prev new ulcers from deve This REQUIREMENT by: Based on observatio and physicians, the fa	vent infection and prevent loping. is not met as evidenced ns and interviews with staff acility failed to follow up with Resident #3) for 1 of 3			F-686 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an	n of	

Event ID: OBYH11

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		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE D. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345509	B. WING			C / 23/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		FEN		915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDI	EEN		ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 686	Continued From pag	e 27	F 686	5		
				admission or agreement by the	provider of	
	1.Resident #3 was a	dmitted to the facility on		the truth of the facts or alleged,		
		ses that included intellectual		correctness of the conclusions	set forth	
		pe 2, and stage 4 pressure		on the statement of deficiencies	•	
	ulcer of the sacrum.			of correction is prepared and su		
	The regident's admis	aion Minimum Data Sat		solely because of the requirement		
		sion Minimum Data Set 2020, indicated the resident		state and federal law and to de the good faith attempts by the p		
		vely impaired, and required		improve the quality of life of eac		
		with all activities of daily				
		ygiene. Resident #3 was		Root Cause:		
		age 4 pressure ulcer during		The Administrator and the Direct	ctor of	
	the assessment perio	od.		Nursing discussed with the IDT	QAPI	
				committee team on 11/06/2020	to identify	
		ler note, written 9/10/2020,		the root cause of this alleged		
		t had a stage 4 pressure		non-compliance. Root cause ar	•	
		and requested a referral to		conducted revealed that the all	-	
	wound care physicial	n.		non-compliance resulted from in training/understanding of the nu	•	
	Review of Resident #	#3's medical records on		on the process of following up of		
		ndicate Resident #3 had ever		care referral to the wound care		
		by a wound care physician		(Vohra).		
		order for wound care				
	physician consult.			For affected resident(s):		
				Resident #3 no longer resides i	n the	
)5am a phone interview was		facility.		
		ician #3. He stated he was			antial ta ba	
		it #3 and aware of her stage her sacrum. He further stated		For other residents with the pot affected:	ential to be	
	-	via telehealth in September		All residents have the potential	to he	
		he wound care physician but		affected by this alleged non-co		
		onsult was completed. He		and as a result, the systemic ch		
	stated he is currently			stated below have been put in p	-	
		lly dictates his history and		prevent any risk of affecting add residents.		
	c.cou critoury.			A 100% audit was completed or	n	
	A phone interview wa	as conducted with Physician		11/9/2020 by the Director of Nu		
		ician, on 10/23/2020 at		ensure that there were no other	-	

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES		(X2) MULTIPLE	CONSTRUCTION		D: 11/17/2020 M APPROVED D. 0938-0391 E SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED	
		B. WING			С	
NAME OF PROVIDER OR SUPPLIER	345509		TREET ADDRESS, CITY, STATE, ZIP CODE	10	/23/2020	
			15 PEE DEE ROAD			
ACCORDIUS HEALTH AT ABERDE	EEN	A	BERDEEN, NC 28315			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
care for residents in t received a referral for she was providing se telehealth during the throughout the COVII On 10/23/2020 at 8:1 conducted with the D regarding the referral Physician #3 would ty note or history and pl write and order and se day. She was not cer made. An interview was con the facility administra 2:00pm. Both the DO stated it was their exp	she does provide wound the facility but she has not r Resident #3. She stated rvices face to face and via month of September and D outbreak. 3am an interview was birector of Nursing (DON) I to wound care. She stated ypically dictate the provider hysical and send it to her or send it with his file the next tain why the referral was not	F 686	 that were missed to the wound car (Vohra). No newly discovered miss referrals were identified. Facility plan to prevent re-occurrer On 11/06/2020 the DON initiated re-education to the nursing staff re the process on how to handle refe that are made to the wound care physician by the facility and/or a fa physician. Facility plan to monitor its perform make sure that solutions are susta An audit sheet will be done by the Administrator, DON, or designee to monitor and ensure that all referra wound care physician (Vohra) are executed. This monitoring process take place daily (M-F) for 3 weeks for 3 weeks, then monthly for 3 mod The Administrator, DON, or design report findings of the monitoring pr to the facility Quality Assurance ar Performance Improvement Comm any additional monitoring or modifi of this plan. The QAPI Committee modify this plan to ensure the facil remains in substantial compliance The facility alleges compliance on 11/9/2020. 	eed ace: garding rals cility ance to ined: o s to the properly will weekly nths. ee will ocess d ttee for cation can ty		

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