PRINTED: 01/05/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 12/02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	REET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 0	00		
	conducted from 11/ Event ID #E4E611.	gation and revisit survey was 19/20 through 12/02/20. 1 of 1 complaint allegation esulting in a deficiency.				
		F600 at a scope and severity				
	The tag F600 consti Care.	ituted Substandard Quality of				
		y began on 11/09/20 and was 20. An extended survey was				
F 600 SS=J	Free from Abuse an CFR(s): 483.12(a)(1	_	F 60	00		12/18/20
	Exploitation The resident has the neglect, misappropriand exploitation as includes but is not licorporal punishmen	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This mited to freedom from at, involuntary seclusion and mical restraint not required to medical symptoms.				
	§483.12(a) The faci	lity must-				
	physical abuse, corp involuntary seclusio	se verbal, mental, sexual, or poral punishment, or n; IT is not met as evidenced				
ABORATORY	I DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE

Electronically Signed

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

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.

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES			OND N	O. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
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		345509	B. WING		1:	2/02/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
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ACCORDI	US HEALTH AT ABERDI	EEN		ABERDEEN, NC 28315		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 1	F 60	00		
		riew and interviews with the		F-600		
	Medical Examiner, at			1 000		
	I .	RP), and staff, the facility		This plan of correction constit	utes a	
		and assess Resident #1 's		written allegation of compliance		
	_	n and vital signs following a		Preparation and submission of		
	_	ent hit his head on concrete.		correction does not constitute	•	
		ected to provide accurate		admission or agreement by the		
	-	ent #1 ' s attending physician		the truth of the facts or allege	•	
	I .	etails of the fall by reporting		correctness of the conclusion		
	I .	onto a grass surface rather		on the statement of deficienci		
	I .	failure caused the physician		of correction is prepared and	•	
		at the facility for monitoring		solely because of the requirer		
	1	he resident out for evaluation		state and federal law and to d		
	at the Emergency Ro	oom (ER). Resident #1 fell		the good faith attempts by the	provider to	
		oncrete on 11/9/20 at 9:55		improve the quality of life of e		
	AM and was found u	nresponsive at 12:48 PM.				
		ath, dated 11/9/20, indicated		Root Cause:		
	the cause of death w	as "blunt force head		The Administrator and the Dir	ector of	
	trauma". Additionally	, the facility neglected to		Nursing discussed with the		
	complete neurologica	al assessments for Residents		interdisciplinary team quality a	assurance	
	#2, #3, #4, and #5 af	ter unwitnessed falls. This		performance improvement pla	an	
	was for 5 of 5 resider	nts reviewed for falls.		committee team (Administrate	or, Director	
				of Nursing, Staff Developmen	t	
	Immediate Jeopardy	began on 11/9/20 when		Coordinator, Admissions Dire	ctor,	
		essed Resident #1 fall		Housekeeping Supervisor, So		
	I .	elchair hitting his head on a		Dietary Manager, Medical Re		
	concrete walkway ou	tside of the facility and his		Coordinator, Business Office	•	
	1	se #1, neglected to obtain		Assistant Business Office Ma	•	
		witness to the fall (Dietary		Maintenance Director) on 12/0		
		uently reported inaccurate		identify the root cause of this		
		ent #1 ' s physician stating		non-compliance. Root cause		
	I .	s head on a grass surface.		conducted revealed that the a	-	
	_	cted to follow the physician '		non-compliance resulted from	•	
	s orders for monitorir	-		training/understanding of the		
		cal assessments (including		to properly investigate a fall, a		
	vital signs) per facility			complete neurological checks		
		e 5 of the neurological		resident that hit their head an		
		ere due on 11/9/20 between		conversations with both the re	sponsible	
	10:15 AM and 12:48	PM (10:15 AM, 10:45 AM,		party and physician.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	COMPLETED	
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	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 600	10:30 AM. At 12:48 was found unrespondent of Resident of Certificate was "blu Immediate Jeopard when the facility produce acceptable credible Jeopardy Removal. compliance at a low (no actual harm with minimal harm that is Examples #2, #3, #deficient practice are education and the replace to remove the effective. The findings includes 1. Resident #1 was on 5/27/12 and most facility on 10/21/20 Gastrointestinal (GI Chronic Obstructive heart disease, hyperhyperlipidemia (HLI Transient Ischemic of cerebral infarction The hospital dischala.)	ident #1 being completed at BPM (11/9/20) Resident #1 nsive in bed in his room. The #1 's death on the Death not force head trauma". If y was removed on 11/25/20 poided and implemented an allegation of Immediate The facility will remain out of wer scope and severity level E in potential for more than is not Immediate Jeopardy) for 4, and #5 to correct the indition to ensure that the monitoring systems put in a Immediate Jeopardy are ed: Initially admitted to the facility st recently readmitted to the with diagnoses that included bleed, respiratory failure, a Pulmonary Disease (COPD), extension (HTN), D), personal history of Attack (TIA), personal history in, and speech disorder.	F 600	For affected resident(s): Resident #1 no longer resides in the facility. Residents #2, #3, #4, and #5 on the experience any adverse outcomes due to the alleged non-compliance. For other residents with the potential thaffected: All residents have the potential to be affected by this alleged non-compliant and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Facility plan to prevent re-occurrence: On 11/23/2020 the Administrator, Directly of Nursing (DON), and nurse management team-initiated re-educated to all staff regarding neglect. An examinating was given that the failure to obtain neurological checks and ongoing assessment of a resident's status after fall with head injury could be considering neglect. Education was completed on 11/24/2020. On 11/23/2020 the DON initiated re-education to the nursing staff on the importance of completing neuro check assessment, notification, and following physician orders after a fall. The nursing staff or the importance of completing neuro check assessment, notification, and following physician orders after a fall. The nursing staff or the importance of completing neuro check assessment, notification, and following physician orders after a fall. The nursing staff or the importance of completing neuro check assessment, notification, and following physician orders after a fall. The nursing staff or the importance of completing neuro check assessment, notification, and following physician orders after a fall. The nursing staff or the importance of completing neuro check assessment, notification, and following physician orders after a fall. The nursing staff or the importance of completing neuro check as a fall in the nursing staff or the importance of completing neuro check as a fall in the nursing staff or the importance of completing neuro check as a fall in the nursing staff or the importance of completing neuro check as a fall in the nursing staff or the importance of completing neuro check and th	to be ce co l cector ion nple er a eed ee cs, g the ng
	8/30/20 through 10/ (PNA) complicated failure and new ons previously on Plavio	#1 was hospitalized from (7/20 for COVID pneumonia by acute hypoxic respiratory eet of atrial fibrillation. He was ((antiplatelet medication) and ry stroke prevention. This was		staff was also re-educated to ask the Managers, Staff Development Coordinator, and/or the Director of Nursing should they have any questio or require guidance and assistance w resident that has had an acute change	ns ith a

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345509	B. WING	B. WING		12/	02/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
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F 600	medication) during the hospitalization. On 19 presented to the hosp stool usually associate confirmed by Emerge exam. He was admitted colonoscopy was condiverticulitis and 3 sm from his transverse of procedure there was gastroenterology felt anticoagulant (Xarelto stable, and he was di on 10/21/20. His discincluded Xarelto 15 m. The annual Minimum assessment dated 10 #1 's cognition was serequired extensive as mobility and transferre the assistance of 2 or locomotion on/off unit twice with 1 assist. Reimpairment with range wheelchair. The Care Area Asses cognitive loss for Resindicated he had difficated to be incontined wore an adult brief, at that had blood preser He was at risk for falls.	ad Xarelto (anticoagulant e 8/30/20 to 10/7/20 0/14/20 Resident #1 oital with melena (black, tarry ed with Gl bleed) which was ency Room (ER) rectal ed to the hospital and a ducted which revealed hall polyps were resected olon. Following the no active bleeding and it was okay to resume his ob. His hemoglobin was scharged back to the facility charge medication orders hilligrams (mg) once daily. Data Set (MDS) 1/21/20 indicated Resident everely impaired. He esistance of 1 with bed ed only once or twice with the more. He was coded for a so only happening once or esident #1 had no functional e of motion and utilized a sment (CAA) related to cident #1 's 10/21/20 MDS culty with completing was able to complete them given ample time. He was not of bowel and bladder, and had bowel movements at since his last hospital stay. Is related to poor balance,	F	600	Education was completed on 11/24/202 On 12/18/2020 an audit was completed the Administrator and the DON to revie all falls that have occurred form 11/25/2020 to present to ensure that if indicated, neuro checks were performed physician and responsible party (RP) notification, and that accurate information was relayed to the physician and RP. Audit revealed all required documentations are sustained A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all falls had a neurological assessment completed if warranted, physician and RP were notified, and that accurate information was given to the physician and RP. This monitoring process will take place daily 3 weeks, weekly for 3 weeks, then monthly for 3 months. The Administrator, DON, or designee were port findings of the monitoring process to the facility Quality Assurance and Performance Improvement (QAPI) Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on the facility alleges compliance.	d by w d, on ion to :	
	thoughts or ideas but when prompted and g noted to be incontined wore an adult brief, al that had blood preser He was at risk for falls	was able to complete them given ample time. He was nt of bowel and bladder, nd had bowel movements nt since his last hospital stay.			or modification of this plan. The QAPI Committee can modify this plan to ensu the facility remains in substantial compliance.	_	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 600	A nursing note dated Nurse #9 indicated the reported Resident #1 which had a significal physician gave order hospital to evaluate at The Emergency Root 10/26/20 indicated Resident #1 was noted and presented for work Resident #1 was noted stating that this bleed when he was hospital back to the facility. Hormal limits and his compared to prior val Responsible Party (Responsible Party (Respon	10/26/20 completed by the Nursing Assistant (NA) had a bowel movement int amount of blood in it. The to send resident to the find treat. In (ER) evaluation dated the evaluation	F6			
	Resident #1 's care p 11/6/20, included the incontinence related range of motion and to bloody stool with c included ER evaluation polyps while hospital included the risk for f problems and inconti	to immobility and limited being sent to the ER related lots. The interventions on and removal of colon zed. This care plan also alls related to gait/balance nence. The interventions and meeting Resident #1 's				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	<u> </u>	12/02/2020
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F 600	witnessed Resident: his wheelchair. The backward onto the gremained in wheelch had not lost conscious an abrasion on the biguarter. Resident ## transferred back to be 2 staff assist. Residing pain or discomfort ar were obtained: blood 101, respirations 20, (O2) 98% room air. physician were notified new order to monitor his head for 7 days as checks per facility proposed to be in bed with the Electronic Medicineurological assessing completed as follows every (q) 15 minutes quantity of the	#1 indicated that staff #1 outside on the ground in wheelchair had flipped round. The resident lair as it flipped. Resident #1 lusness. He was noted with lack of his head the size of a I was taken to his room and led via a mechanical lift with lent #1 had no complaints of lind no open areas. Vital signs I pressure (bp) 135/81, pulse I temperature 97.1, Oxygen Resident #1 's RP and led, and the physician gave a I the abrasion to the back of land to complete neurological lotocol. The resident was latching television. I blogical assessment record in latal Record (EMR) indicated ments were supposed to be list les 4 times les les les lesses l	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 12/02/2020	
	ROVIDER OR SUPPLIER	EEN	ı	91	REET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD BERDEEN, NC 28315	1 12/	02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	- 11/9/20 at 10:10 AM of Nursing (DON): bp - 11/9/20 at 10:30 AM 100/60, respirations pulse 92	perature 97.1, pulse 101 I completed by the Director	F	600			
	completed by Nurse picked up Resident # the nurse that the res Nurse #1 observed F pulse, respiration, blo	#1 indicated that NA #1 f1 's lunch tray and informed sident was not responding. Resident #1 who had no					
	as a late entry note)	11/9/20 at 2:26 PM (noted indicated Unit Manager (UM) Resident #1 's passing that nately 12:48 PM.					
	the Medical Examine cause of Resident #' head trauma". The N the injury occurred fr	n dated 11/9/20 completed by er identified the immediate I 's death as "blunt force Medical Examiner noted that om Resident #1 falling hair onto concrete. The time PM.					
	approaching the side and saw Resident #1 back causing him to concrete sidewalk.	nent dated 11/10/20 y Staff #1 indicated she was ewalk in back of the facility flip his wheelchair on its bump his head on the Dietary Staff #1 stated she the resident opened his eyes					

AND DIAN OF CORRECTION INTERPRETATION NUMBERS		l ` ′	LE CONSTRUCTION G	COMPLETED	
		345509	B. WING		C 12/02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
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F 600	building and asked Nassistance. Dietary got Nurse #2 she ret department. On 11/19/20 at 12:14 conducted with the was 11/9/20 fall, Dietary she was outside on Resident #1 's fall. coming back from he Resident #1 seated is sidewalk. She indica activity for the reside outside independent like Resident #1 had wheelchair stuck in the concrete sidewalk are movement to get it be Staff #1 stated that Frocked with too much tipped all the way be not the concrete with seated in the wheelch saw Resident #1 hit she indicated she as alright and he responsas okay. She state facility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened, and he refacility to get nursing at the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static happened and he responsed to the nurse 's static hap	She then ran into the lurse #2 to provide Staff #1 indicated after she	F 60		

PREFIX TAG EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
APPROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN ABERDEEN, NO. 28315 SUMMARY STATE-MENT OF DEFICIENCIES (EACH DEPICIENCY MIST BE REPECTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 8 A physician 's note dated 11/12/20 at 7:23 AM indicated she was informed by staff on 11/9/20 that Resident #1 had fallen outside onto grass striking the back of his head. The physician wrote that the staff member (Nurse #1) was asked if Resident #1 fell on concrete or the grass and she confirmed it was the grass. The physician indicated that Nurse #1 reported he was cognizant to his surroundings, had not lost consciousness, and had no raised area on his head. The physician further indicated she decided that neurological checks were to be performed for Resident #1 every 15 minutes in accordance with the facility protocol and any changes in mentation were to be reported to her. An interview was conducted with the DON on 11/19/20 at 1:30 PM. When asked about the facility 's protocol of renurological checks she stated that the assigned nurse was to complete the neurological assessment in the EMR at the following frequency: q 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2. She reported the neurological assessment included vital signs. She stated that the assigned NA was able to obtain vital signs for the nurse, but the NAs were not able to complete the remainder of the neurological assessment at it required a nurse 's clinical assessment at it required a nurse 's clinical assessment as it required a nurse 's clinical assessment as it required a nurse 's clinical assessment. The			345509	B. WING _				
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DON reported that ultimately it was the assigned nurse 's duty to ensure neurological assessments with vital signs were conducted in accordance with this protocol. An interview was conducted with Nurse #2 on 11/19/20 at 12:20 PM. He stated that on 11/9/20		indicated she was in that Resident #1 had striking the back of hwrote that the staff masked if Resident #1 and she confirmed it physician indicated twas cognizant to his consciousness, and head. The physician decided that neurolo performed for Reside accordance with the changes in mentatio An interview was con 11/19/20 at 1:30 PM facility 's protocol fo stated that the assig the neurological assifollowing frequency: minutes x 2, q 1 hou shift x 2. She report assessment included the assigned NA was the nurse, but the NA the remainder of the it required a nurse 's DON reported that unurse 's duty to ensuassessments with vitaccordance with this	formed by staff on 11/9/20 If fallen outside onto grass his head. The physician hember (Nurse #1) was fell on concrete or the grass was the grass. The hat Nurse #1 reported he surroundings, had not lost had no raised area on his further indicated she gical checks were to be ent #1 every 15 minutes in facility protocol and any n were to be reported to her. Inducted with the DON on When asked about the r neurological checks she hed nurse was to complete essment in the EMR at the q 15 minutes x 4, q 30 r x 4, q 4 hours x 6, and q ed the neurological d vital signs. She stated that is able to obtain vital signs for As were not able to complete neurological assessment as is clinical assessment. The litimately it was the assigned ure neurological tal signs were conducted in protocol.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 1 2/02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERD			STREET ADDRESS, CITY, STATE, ZIP COI 915 PEE DEE ROAD ABERDEEN, NC 28315		12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	help stating that Res wheelchair. He repored #2, and the Activities out to assist the residence Resident #1 was obside wheelchair with his work concrete ground. He the position an astroitakeoff as his back wheel was looking up toward that Resident #1 was baseline cognitive stransked Resident #1 if resident said no. He him with putting the rupright. He indicated an abrasion to the back Nurse #2 reported the sassigned nurse, Nurse #2 reported the sassigned nurse, Nurse #1 information about the yelling to NA #1 and Resident #1 inside to assess him. Nurse #1 occurrence for Residown. A phone interview was (an agency nurse) or stated that she had refall on 11/9/20. She room with another recommotion. She individed what she was doing indicated that when stated that wh	n from outside and asked for ident #1 had flipped his rted that he and NA #1, NA Staff/NA #3 immediately ran dent. He reported that	F 60			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345509	B. WING				02/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
ACCORDI	US HEALTH AT ABERD	FFN		9	15 PEE DEE ROAD		
7,000,000,000,000,000		ZEN		Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 600	#1 indicated that Nu flipped his wheelchat fine, and that he had of his head. She sat the size of a quarter reported that she the grass as the resident She stated she told Resident #1 inside a could take his vitals. Resident #1 if he was he said no. She stated and completed a ne 10:00 AM and these Nurse #1 was unabl neurological assess record. She reporte her assessment she her that Resident #1 grass. She stated the vitals to the physician physician ordered no minutes per protoco called the RP and to fallen outside and hid doing fine. Nurse #1 to Dietary Staff #1 wasked why she had she stated that she Resident #1's fall. assumed Resident # since he had grass of this interview with North the state of the resident # since he had grass of the state of the resident # since he had grass of the state of the resident # since he had grass of the state of the resident # since he had grass of the state of the resident # since he had grass of the state of the resident # since he had grass of the state of the resident # since he had grass of the state of the resident # since he had grass of the resident # since he h	's wheelchair upright. Nurse rse #2 said Resident #1 just air over on the sidewalk, was d a small abrasion to the back id she observed an abrasion to the back of his head. She ought Resident #1 fell on the at had some grass on him. NA #1 and NA #2 to take and put him in bed, so she She reported she asked anted to go to the hospital and ted that she took his vitals urological check around awere within normal limits. The to explain why this initial ment was not in the medical did that after she completed a called the physician and told fell and hit his head on the hat she also provided the the curological checks every 15 less the she had not spoken who witnessed the fall. When the had on grass and was revealed she had not spoken who witnessed the fall. When the spoken to Dietary Staff #1 thad not known she witnessed She reiterated that she thad fallen on the grass on him. Jurse #1 continued. Resident	F	600			
	Resident #1 ' s 11/9	d that indicated no ments were completed after //20 fall was reviewed with					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		C 12/02/2020
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 600	11/9/20, the initial che the fall around 10:00 around 10:30 AM. So no irregularities with #1 was unable to expended she had not complete assessments that we AM, 10:45 AM, 11:30 #1 explained that she and she didn 't have the neurological assessments. During an interview of the protocol. She acknown A #1 was not able to assessments. During an interview of 12:00 PM she report Dietary Staff #1 report Had fallen so she assistance. She conseated in his wheeled wheelchair laying on stated she observed his head. NA #1 state outside as she and the protocol wheelchair upright outside, lay him down NA #1 stated that Nu continue to take Resminutes after that. Sesident #1 's vitals Resident #1 's vitals	hecks for Resident #1 on eck that occurred soon after AM and a subsequent check he indicated that there were these assessments. Nurse blain why the neurological conducted at 10:30 AM was al record. When asked why	F 60		

AND DUAN OF CORRECTION TO THE PROPERTY OF THE		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 12/02/2020
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	explained that this we documentation of vit the EMR, so they we nurse was supposed NA #1 revealed that vitals for Resident # very busy that mornithe NAs scheduled toff, so the nurses we residents ' vitals that NAs ' work. NA #1 aware one of the NA expected her to take stated that after 10:3 in his room a couple and down the hall ar lunch tray and he see During a phone interphysician on 11/20/2 the nurse who called said Resident #1 fell She reported that shoutside where Resident that grass and garea. She indicated staff (Nurse #1) if he grass and they state explained that a fall different and if she ke concrete she would them to send Reside further explained that suffered internal injurobserved on the initit that she instructed the	at the nurse's station. She has the normal process for NA als as they had no access to ote them down and then the it to enter them into the EMR. She had taken no further it after 10:30 AM as she was ng. She stated that one of o work that day had called be reinstructed to take the it day to alleviate some of the reported that Nurse #1 was is had called off, but she is the vitals anyway. NA #1 so AM she saw Resident #1 of times as she walked up and when she delivered his emed to be his normal self. In and hit his head on grass, we was familiar with the area ent #1 was at and she knew round were very soft in that she specifically asked the if ell on the concrete or on digrass. The physician onto concrete was very new he had fallen on have immediately ordered ent #1 to the hospital. She it Resident #1 could have ries that were not able to be all assessment. She reported he staff (Nurse #1) to perform according to protocol.	F 60			

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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 600	unaware the neurole completed per prote about Resident #1 ' that he recently had a GI bleed, and was had to be discontinuindicated that with the pertinent to maintain complete neurologic protocol as she orde contacted her on 11. A phone interview w #1 's RP on 11/19/2 that the nurse who will will be will be a said that he will the staff had it concrete and hit his them to send him to She explained that I wanted to go to the spoken with him her agreed to go to the spoke about Reside GI bleed. She state factor should have reprecautions with meaning an interview she confirmed that so of Death for Resider of death was "blunt reported that no aut were normally only and this death was serviced."	sician revealed she was opical checks had not been ocol. The physician spoke is medical condition stating COVID, was hospitalized for a recently on Xarelto which used due to bloody stool. She nese medical issues it was in close monitoring and call checks per the facility is ered the nurse (Nurse #1) who /9/20. The stated conducted with Resident conducted with Resident conducted had been on 11/9/20 (Nurse 11 fell and hit his head on as doing fine. She reported informed her that he fell onto head she would have asked the Emergency Room (ER). Resident #1 may not have hospital, but if she had reself that he would have ER to be evaluated. The RP int #1 is recent issues with a did that she believed this risk made staff take extra unitoring Resident #1 is status	F 600				

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		345509	B. WING _			C 12/02/2020	
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	'		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 600	concrete and less the deceased. She state the fall was not the caminimum it was pathe death. The Med Resident #1's medi included recent COV hospitalization due to that these multiple makesident #1 at a high complications after a made it essential to monitor him closely checks and vital sign explained that althous baseline following the continue to monitor hwere any changes to not have presented in as a subdural brain has a subdural brain has a subdural brain has a subdural staff how frequently Resident where the sumble to recall staff how frequently Resident where any changes to not have presented in the specific answer to the sumble to recall staff how frequency. That if the neurologic completed as orderer Resident #1's fall the nursing staff. During an interview of the sumble to recall staff the neurologic completed as orderer resident #1's fall the nursing staff.	an 3 hours later he was ed that it was highly unlikely cause of the death and that at art of the causation that led to ical Examiner spoke about cal comorbidities that //ID infection and or rectal bleeding. She stated hedical conditions put ther risk for severe in fall with head injury which his well-being for staff to by completing neurological his. The Medical Examiner high Resident #1 presented at he fall, it was necessary to him closely to see if there his indicate an injury that would himmediately after a fall, such holeed. he spoke with facility staff, 's name, and questioned hent #1 had been assessed hey were unable to provide a he number of assessments he Medical Examiner stated	F 6				

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NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
A C C O D D I	HE HEALTH AT ABEDI	DEEN		9	15 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERI	DEEN		Δ	ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	entered the first set fall in the EMR with She indicated that se reported that she to approximately 10:00 approximately 10:30 she reviewed the vi NA #1 recorded on reported that the repulse that NA #1 recorded on the AM. The DON explipation with the political signs that were Nurse #1 were transecorded on the hard further explained the pressure (135/81) fin NA #1 had not been she entered this interest time as that NA #1 indicated signs. The DON stavitals completed by approximately 10:30 she entered them he that her documental completed after Research and be 11/9/20 fall was revered by a proximately 10:30 she entered them her documental completed after Research and be 11/9/20 fall was revered by a proximately 10:30 she entered them her documental completed after Research and be 11/9/20 fall was revered by a proximately 10:30 she entered them her documental completed after Research and be 11/9/20 fall was revered by a proximately 10:30 fall was revered by	I. She indicated that Nurse #1 of vitals after Resident #1 's a date of 11/9/20 at 9:56 AM. She spoke to NA #1 who look two sets of vitals, one at 0 AM and the other at 0 AM. The DON stated that tal signs for Resident #1 that a hard copy paper. She spirations, temperature, and corded at approximately 10:00 matched Nurse #1 's are EMR dated 11/9/20 at 9:56 lained that she believed the arecorded in the EMR by scribed from the vitals NA #1 and copy paper. The DON at Resident #1 's blood from this set of vitals taken by an documented in the EMR so to the EMR with a time of orted that she should have 10:00 AM to match the time dishe obtained these vital sted that since second set of NA #1 (obtained 11/9/20 at 0 AM) were not in the EMR erself. The DON reported tion in the EMR was sident #1 's death. The sment record in the EMR esident #1 that indicated no een completed after his iewed with the DON. The was aware there were no sments in the EMR for is 11/9/20 fall. She was	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				02/2020
	ROVIDER OR SUPPLIER	EEN		91	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	1 12/	02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	and hit his head on cophysician and RP we he hit his head on gradon. She was unable had not obtained the witness (Dietary Staf Nurse #1 no longer was an interview was con Administrator on 12/2 revealed that neurolot to monitor a resident baseline. She explain injury there could be that were not able to observation. She fur essential to inform the known about a fall in able to make sound the up care/monitoring. The Administrator is acted with "poor judgintend to provide the accounting of Reside had not willfully interneurological checks. The Administrator extends the property of the provided the counting of Reside had not willfully interneurological checks. The Administrator extends the provide the accounting of Reside had not willfully interneurological checks.	the record review and led Resident #1 had fallen oncrete, but that the greenotified by Nurse #1 that has were reviewed with the pole to explain why Nurse #1 details of the fall from the ff #1). The DON stated that worked at the facility. Inducted with the DON and 2/20 at 10:35 AM. The DON and 2/20 at 10:35 AM. The DON and actions from their ned that after a fall with head things going on internally be seen with a visual ther revealed that it was a physician of all details order for the physician to be creatment decisions for follow The DON and Administrator was also important to inform all known details of a fall as a resident 's decision on the explanation at the hospital atted that he felt this incident and as neglect as Nurse #1 dement" and did not willfully physician with an inaccurate ent #1's fall and she also	F	600			
	The Administrator an	d DON were notified of the					

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		345509	B. WING				02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN	•	9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 600	On 11/25/20 at 3:39 If following credible alled Jeopardy removal: Identify those recipier are likely to suffer, as a result of the noncorn. Resident #1 was re-at 10/21/2020 for long to was evaluated by PT Resident was noted to self-propel wheelchaid outside by himself with frequently went outside incidents leading to the have a history of falls 4/1/19. Resident had failure, TIA, cerebral fibrillation, hypertensis bleed and COVID-19. On 11/9/2020 at approximate worker #1 corn Witnessed to have fall outside on sidewalk addictary worker #1 corn Witness observed pawheelchair came off that attempted to get the sidewalk, he tipped be hitting his head on the to resident to make shelp. Licensed nurse and noted a small schead. Patient was co any change in cognition.	on 11/23/20 at 11:12 AM. PM the facility provided the egation of Immediate Ints who have suffered, or serious adverse outcome as impliance. Idmitted to the facility on earn care services. Resident or and ST on 10/22/2020. To staff to be able to rand was able to get thout assistance. Resident de and had not had any prior nis event. Resident did not assistance is respiratory infarct, COPD, atrial on, along with a history of Glook. In ox. 9:55 AM Resident was also backwards in wheelchair area off patio witnessed by a ming in from the parking lot. Itient's left wheel of his the sidewalk and when he	F	6000			

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	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, 2 915 PEE DEE ROAD ABERDEEN, NC 28315		2/02/2020	
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F 600	Resident was assis the nurse #2 and of was subsequently to further evaluation for primary nurse, nur	ted back up into wheelchair by ther staff members. Resident aken back to his room for or any additional injuries by his e #1, along with initiation of ther injuries were noted, and his baseline for cognitive asked if he would like to go to valuated stated no. Residents 'ided by nurse #1 who initially ident may have hit his head see she noted grass on the ents ' representative (RP) was see #1 that resident had fallen need at approximately 10:25 to ask any further questions. For communication with the RP shurse 1 notified the physician on the facts asking and assessing the and she had not spoken with the was the witness at the time. The ector of nursing started the full diately after the incident but aware that the resident hit his	F	600			

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(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I	BE COMPLETION	
minutes x2, 60 minuthen shift 2. Statemshow that the physicon the concrete. Redid not want to go to Resident also stated At approx. 12:48 PM assistant (CNA) we and noticed that the CNA ran to get the residents ' room the of Nursing (DON), at the resident had a Do Not Resuscitar passed. Primary Ph The CNAs had been approximately every until 1245pm and vitwo of these observed being obtained at 10 vitals taken. After 10 impression that the with the neuro-check any observation cor condition of the resident of the resident of the condition of the resident of t	ents from nurse #1 did not cian asked if he hit his head sident #1 also stated that he to the hospital as well. It did not retrieve his lunch tray resident was unresponsive. The attending nurse, the Director and unit manager discovered did a faint pulse. Resident was te (DNR) and subsequently ysician and RP were notified. In in the residents 'room at y 30 minutes starting at 10 am tal signs were obtained during ations with the second set D:30 AM which were the last D:30 the CNA was under the vital signs would be included ks by nurse #1. At no time did include with a change in dent prior to 1245 pm. The sistants observed the resident r simple questions and did not the resident 's normal ares #1 stated the neurological peted twice at 10:00 AM and sich she failed to completely on the statement of nurse #1 mplete and document the sibut became busy with ents. The number of times due	F 60			
	Continued From page minutes x2, 60 minutes x2, 60 minuten shift 2. Statem show that the physic on the concrete. Redid not want to go to Resident also stated At approx. 12:48 PM assistant (CNA) we and noticed that the CNA ran to get the residents ' room the of Nursing (DON), at that the resident had a Do Not Resuscitar passed. Primary Ph The CNAs had been approximately every until 1245pm and vitwo of these observed being obtained at 10 vitals taken. After 10 impression that the with the neuro-check any observation cornodition of the resident of the with the neuro-check any observation cornodition of the resident of the condition of the resident of the c	CORRECTION IDENTIFICATION NUMBER: 345509	OVIDER OR SUPPLIER IS HEALTH AT ABERDEEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 minutes x2, 60 minutes x4, four hours x6, shift 1 then shift 2. Statements from nurse #1 did not show that the physician asked if he hit his head on the concrete. Resident #1 also stated that he did not want to go to the hospital as well. Resident also stated that he did not hit his head. At approx. 12:48 PM the certified nursing assistant (CNA) went in to retrieve his lunch tray and noticed that the resident was unresponsive. CNA ran to get the nurse. Upon arrival to the residents ' room the attending nurse, the Director of Nursing (DON), and unit manager discovered that the resident had a faint pulse. Resident was a Do Not Resuscitate (DNR) and subsequently passed. Primary Physician and RP were notified. The CNAs had been in the residents ' room at approximately every 30 minutes starting at 10 am until 1245pm and vital signs were obtained during two of these observations with the second set being obtained at 10:30 AM which were the last vitals taken. After 10:30 the CNA was under the impression that the vital signs would be included with the neuro-checks by nurse #1. At no time did any observation conclude with a change in condition of the resident prior to 1245 pm. The Certified nursing assistants observed the resident to be able to answer simple questions and did not note any change in the resident's normal everyday status. Nurse #1 stated the neurological checks were completed twice at 10:00 AM and 10:30 AM and of which she failed to completely document. Based on the statement of nurse #1 she did intend to complete and document the neurological checks but became busy with several other residents. The number of times due of neurological checks with vitals not complete by nurse #1 as instructed by the physician and in	OVIDER OR SUPPLIER 345509 STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 19 minutes x2, 60 minutes x4, four hours x6, shift 1 then shift 2. Statements from nurse #1 did not show that the physician asked if he hit his head on the concrete. Resident #1 also stated that he did not want to go to the hospital as well. Resident also stated that he did not hit his head. At approx. 12-48 PM the certified nursing assistant (CNA) went in to retrieve his lunch tray and noticed that the resident was unresponsive. CNA ran to get the nurse. Upon arrival to the residents' room the attending nurse, the Director of Nursing (DON), and unit manager discovered that the resident had a faint pulse. Resident was a a Do Not Resuscitate (DNR) and subsequently passed. Primary Physician and RP were notified. The CNAs had been in the residents' room at approximately every 30 minutes starting at 10 am until 1245pm and vital signs would be included with the neuro-checks by nurse #1. At no time did any observations with a change in condition of the resident prior to 1245 pm. The Certified nursing assistants observed the resident to be able to answer simple questions and did not note any change in the resident to normal everyday status. Nurse #1 stated the neurological checks were completed twice at 10:00 AM and 10:30 AM and of which she failed to completely document. Based on the statement of nurse #1 she did intend to complete and document the neurological checks but became busy with several other residents. The number of times due of neurological checks with vitals nato complete by nurse #1 as instructed by the physician and in	

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F 600	10:45 AM for the Q 1 AM for the Q 30 minutes che 30 minutes #3. Patie baseline the entire tin non-clinical statemer floor. There were no licensed nursing staf neurological assess. There were no clinical by licensed nursing seneurological assess. Root cause analysis alleged non-compliant training/understanding properly investigate an neurological checks head and document RP and physician. Thour and 5 day report the facilities investigated and to obtain all the dephysician and RP no obtain and document checks. She indicated other residents. A 24-hour initial allegon 11/25/2020. Specify the action the process or system facilities of the process of the process or system facilities of the process of th	every) 15 minutes check #2, 5 minutes check #4, 11:00 ates check #1, 11:30 AM for eck #2, 12:00 PM for the Q nt remained at his cognitive me according to all ats of the NAs working on the clinical assessments by fafter the 10:30 AM ment completed by Nurse #1. The staff after the 10:30 AM ment completed by Nurse #1. The conducted revealed that the ence resulted from inadequate and of the staff on how to a fall, assess and complete on a resident that hit their conversations with both the ence it was noted that Nurse ent but did not willfully intend details prior to calling the redid she intentionally not at vital signs and neuro dishe got very busy taking of the entity will take to alter the entity will take to alter the illure to prevent a serious moccurring or recurring, and	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345509	B. WING				02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN	1	915	REET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD BERDEEN, NC 28315		02/2020	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 600	ensure an assessmeneurological checks of the was noted that Neubeing completed. Lice re-educated by the DNovember 11 regardineurological checks and Q 15 minutes X 4, Q and Q 4 hours X 6 are along with document medical record. On 11/10/2020 the Annurse management the and their causes, fall neuro check required hazards. This re-educated results are relayed to the phological checks are relayed to the phological checks are relayed to the phological checks. On 11/23/2020 the Annurse management the and their causes were physician orders by the 11/24/2020. On 11/23/2020 the Annurse management the failure to obtoon going assessment a fall with head injury neglect. Completed the Nurse #1 was instructive that the failure to obtoon the phological completed that the failure to obtoon going assessment a fall with head injury neglect. Completed the phological checks are the phological checks and the phological checks are the p	hours were reviewed to nt was completed and were completed if indicated. Irological checks were not ensed nurses were irector of Nursing on ng the completion of according to the standard of 30 minutes X2, Q 1 hour X4 and Q shift X 2 after a fall ation of the checks in the diministrator, DON, and the eam-initiated re-education to process on assessing falls care path, falls quick view, ments, and environmental cation includes and for neurological checks and elected that a resident hit their at accurate details of the fall sysician. The re-educated on following the Director of Nursing on diministrator, DON, and the eam-initiated re-education to glect. An example was given ain Neurological checks and of a resident 's status after could be considered	F	600				
		neuro checks along with						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345509	B. WING			l	02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 600	the facility after 11/9/2 The licensed nurses ask for assistance wiresident with acute of was completed on 11 The licensed nurses 11/24/2020 by the DC completing neuro che notification, and follow after a fall. The Admin monitor this process. An audit sheet will be DON, or designee to on a daily basis to en assessment was comwhat information was relayed to the RP and IJ removal date: 11/2 The facility alleges the Jeopardy on 11/25/20 On 12/2/20 the credit Jeopardy removal was verification. Record in had falls after 11/25/2 neurological assessment was completed each day assessments were completed each day assessments were completed assessments were completed each day assessments were completed each da	e #1 no longer worked for 2020. were re-educated to always th assignment if they have a manges and this education /24/2020 by the DON. were re-educated on DN on the importance of ecks, assessment, wing the physician orders nistrator and the DON will daily. e done by the Administrator, monitor and review all falls issure that a neurological inpleted if warranted and a documented that was diphysician. 5/2020 e removal of Immediate DON in the province of Immediate as validated by onsite review of all residents that	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING				02/2020
NAME OF P	ROVIDER OR SUPPLIER	343309	B. Wille	s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	02/2020
	US HEALTH AT ABERDE	EEN		9	15 PEE DEE ROAD ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	to the allegation of net 11/25/20, was review completed and faxed previous phone intervat 11:16 AM) confirms management at the faneurological assessmance been completed physician. She addit working at the facility inservices and Q 4 hours X 6 and Q 4 hours X 6 and Q 4 hours X 6 and along with documentamedical record; 2) the and their causes, fall neuro check requiren hazards, the need for vital signs when its statistic thead, and ensure the fall are relayed to following physician or and the fact that the fachecks and ongoing a status after a fall with considered neglect; at a always ask for assessignment if they have	The 24 hour report related eglect for Resident #1, dated ed and confirmed to be to the state agency. A view with Nurse #1 (11/20/20 ed she spoke with acility who told her the nents and vital signs should das ordered by the ionally confirmed her last day was 11/9/20. A review of ice sign in sheets as well as various disciplines (Nurses, taff, Activities staff) verified led for the required llowing: 1) the completion of according to the standard of 30 minutes X2, Q 1 hour X4 and Q shift X 2 after a fall action of the checks in the exprocess on assessing falls care path, falls quick view, ments, environmental resident hit ring that accurate details of the physician and RP; 3) reders; 4) the neglect policy failure to obtain neurological assessment of a resident 's in head injury could be and 5) staff were instructed istance with their live a resident with acute 's IJ removal date of	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345509	B. WING		C 12/02/20)20	
	ROVIDER OR SUPPLIER US HEALTH AT ABERI	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 .2.02.232		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE COM	(X5) IPLETION DATE	
F 600	9/4/20 with diagnos Mellitus type 2 and The modified admis (MDS) assessment Resident #3's cogrammers of the risk for fand unawareness of initiated on 9/12/20 intervention of follow. An interview was conversing (DON) on 1 asked about the fact neurological checks nurse was to compliassessment in the E(EMR) at the following type 2 and 2	admitted to the facility on es that included Diabetes unspecified convulsions. sion Minimum Data Set dated 9/12/20 indicated nition was severely impaired. ors and no rejection of care. esident #3 included the focus alls related to deconditioning if safety needs. This area was and included, in part, the wing the facility fall protocol. Inducted with the Director of 1/19/20 at 1:30 PM. When sility 's protocol for she stated that the assigned ete the neurological Electronic Medical Recording frequency: every (q) 15 inutes x 2, q 1 hour x 4, q 4	F 60				
	indicated Resident in 11/8/20 at 9:00 PM.	w note completed by Nurse #8 #3 had an unwitnessed fall on The resident rolled out of oor. Resident #3 was juries.					
	assessment record at 9:00 PM revealed assessments were 4 hours #1, q 4 hou hours #4). The rem	nt #3 's neurological initiated after her 11/8/20 fall d 5 of the 18 neurological not completed (q 1 hour #4, q rs #2, q 4 hours #3, and q 4 laining neurological completed and were all within					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING			l	02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN	'	9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	assignments and docrecord the following is Resident #3 when newere due, but were nowere due, but were nowere due, but were nowere due, but were nowere was assig was due. Nurse #1 was assig #1 and q 4 hours cheorem was assig #3 and q 4 hours cheorem was nower and no	the nursing schedule with sumentation in the medical staff were assigned to surological assessments of completed: ned when q 1 hour check #4 aned when q 4 hours check took #2 were due. ned when q 4 hours check took #4 were due. The statement of the seconducted with Nurse #8 and the nurse who worked with prior informed the oncoming all assessment needed to be sir shift. The q 4 hours check took #2 that were not tent #3 's fall that occurred on the seessments for Resident #3 and the assessments were she recalled Nurse #8 and had not provided her with shift on 11/9/20.	F	600			
	on 11/30/20 at 3:25 F	es conducted with Nurse #4 PM. Nurse #4 reiterated v stating that the nurse who					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C 12/02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		12/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	the oncoming nurse needed to be completed indicated that this rebetween the nurses didn't occur that the would most likely be check #3 and q 4 ho completed for Reside 11/8/20 fall at 9:00 P #4. Nurse #4 was un	e 26 dent the shift prior informed if a neurological assessment eted during their shift. She quired communication and if this communication e neurological assessment missed. The q 4 hours urs check #4 that were not ent #3 's fall that occurred on M were reviewed with Nurse lable to recall why she had neurological assessments	F 60	00			
	DON on 12/2/20 at 1 that neurological chemonitor a resident for baseline. She explaid were conducted after was a possibility that their head. She furth resident had hit their complications could able to be seen with DON stated that she	was conducted with the 0:35 AM. The DON revealed cks were essential to r deviations from their ined that neurological checks r unwitnessed falls as there the resident may have hit ner explained that if the head during the fall that occur internally that were not a visual observation. The expected all neurological ted as per the facility					
	Resident #3 had an She was found lying and was unable to s Resident #3 was ass A review of Resident	sessed with no injuries.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 12/02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	PEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	D BE COMPLETION	
F 600	assessments were r q 4 hours #5, and q neurological assess were all within norm Based on review of assignments and do record the following Resident #3 when n were due, but were - Nurse #8 was assis #4 and q 4 hours ch - Nurse #3 was assis #6 was due. A phone interview w on 11/23/20 at 5:32 reached. A phone interview w on 11/23/20 at 5:37	d 3 of the 18 neurological not completed (q 4 hours #4, 4 hours #6). The remaining ments were completed and all limits. the nursing schedule with cumentation in the medical staff were assigned to eurological assessments not completed: gned when q 4 hours check eck #5 were due. gned when q 4 hours check as attempted with Nurse #8 PM. She was unable to be as conducted with Nurse #3 PM. Nurse #3 was asked	F 60	<u> </u>		
	due. She stated that the resident the shift nurse if a neurologic completed during the this required community and she revealed the always occur. She adays that the shift set there were things the one of the neurologic hours check #6 that Resident #3's fall the 8:05 PM was review was unable to recall	urological assessment was at the nurse who worked with a prior informed the oncoming cal assessment needed to be eir shift. She indicated that unication between the nurses at this communication did not added that there were some eemed to be non-stop and at could get missed, such as cal assessments. The q 4 was not completed for not occurred on 11/10/20 at wed with Nurse #3. Nurse #3 why she had not completed sessment for Resident #3.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING	R WING		C 12/02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	l		9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315	12/	02/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	DON on 12/2/20 at 10 that neurological checmonitor a resident for baseline. She explain were conducted after was a possibility that their head. She furth resident had hit their complications could cable to be seen with a	was conducted with the D:35 AM. The DON revealed cks were essential to deviations from their ned that neurological checks unwitnessed falls as there the resident may have hit er explained that if the head during the fall that occur internally that were not a visual observation. The expected all neurological	F	600			
	10/28/20 with diagnost dementia with behavious obstructive pulmonary of Transient Ischemic infarction without resivascular disease. The admission Minimassessment dated 11	/4/20 indicated Resident #4 '					
	The care plan for Resarea of the risk for fal gait/balance problems needs, and history of initiated on 11/2/20 arincluded, in part, folloo A nursing note dated Nurse #4 indicated R	sident #4 included the focus ls related to confusion, s, unawareness of safety falls. This area was not the interventions w facility fall protocol.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING	B. WING		C 12/02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN	1	9	STREET ADDRESS, CITY, STATE, ZIP CODE D15 PEE DEE ROAD ABERDEEN, NC 28315	122	02/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B) TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE	
F 600	stated that he hit his I with no injuries. Neurinitiated. The physici Resident #4 be sent to (ER) for evaluation. If (EMS) were notified a building at 7:55 PM a #4 at 8:00 PM. A nursing note dated Nurse #4 at 11:07 PM returned to the facility orders. A review of Resident assessment record in fall at 7:30 PM reveal assessments were not check #1, #2, #3, #5, and 1 of the assessments to Resident #4 being (q 15 minutes check # were 4 assessments to Resident #4 being (q 15 minutes check #1 and #2; q 1 remaining neurological completed and were were the facility neurological checks in assessment in the Elect (EMR) at the following interview was completed assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was to complete assessment in the Elect (EMR) at the following interview was contained to the physical properties as the physical properties are the physical properties at the physical properties and the physical properties are the physical pr	ear the wall. Resident #4 mead. He was assessed rological checks were an was notified and ordered to the Emergency Room Emergency Medical Services at 7:45 PM, arrived at and left facility with Resident 11/18/20 completed by 1 indicated Resident #4 at 10:30 PM with no new #4 's neurological at itiated on 11/18/20 after his and #6; q shift check #2) thents was completed 3 hours and #6; q shift check #2) thents was completed due out of the facility at the ER and #4; q 30 minutes thour check #1). The al assessments were within normal limits. ducted with the Director of 19/20 at 1:30 PM. When try 's protocol for the stated that the assigned	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			C 12/02/2020
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	•	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	on 11/24/20 at 10:41 reached. Nurse #6 chour check #4 3 hour rather than the 1:15. Based on review of the assignments and door record the following seed Resident #4 when nowere due, but were record the following seed at 11/19/20 1st shift (7 - 11/19/20 1st shift (7 - 11/19/20 1st shift (7 - 11/20/20 1st shift (7 - 1	as attempted with Nurse #6 AM. He was unable to be completed Resident #4 ' s q 1 rs late (11/19/20 at 4:15 AM AM due time). The nursing schedule with cumentation in the medical staff were assigned to eurological assessments not completed: 2:00 AM - 3:00 PM) Nurse #2 3:00 PM - 11:00 PM) Nurse 2:00 AM - 3:00 PM) Nurse #2 As attempted with Nurse #2 AM. He was unable to be The nurse who worked with prior informed the oncoming all assessment needed to be be set shift. She indicated that nication between the nurses ation didn't occur that the ment would most likely be on 11/19/20 during the 2nd ompleted were reviewed with was unable to recall why she	F 6			

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345509	B. WING			12/	02/2020
	OVIDER OR SUPPLIER JS HEALTH AT ABERDE	EN		9	STREET ADDRESS, CITY, STATE, ZIP CODE 115 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	were conducted after was a possibility that their head. She further resident had hit their I complications could of able to be seen with a DON stated that she checks to be complete protocol. 4. Resident #2 was ac 2/4/19 with diagnoses. The care plan for Resfor falls related to consafety needs. This a and had been revised 2/5/20, and 4/10/20. In part, neurological conference of 1/18/20, 2/5/20, and 4/10/20. The quarterly Minimum assessment dated 8/5 sognition was sever behaviors and no reject A post fall review note Resident #2 had an under the was seen on the fifetal position on his rigassessed with no injurance of the conduction of the session of the session of the fifetal position on his rigassessed with no injurance of the conduction of the session of the fifetal position on his rigassessed with no injurance of the conduction of the session of the fifetal position on his rigassessed with no injurance of the conduction of the fifetal position on the fifetal position on his rigassessed with no injurance of the conduction of the conductio	cks were essential to deviations from their ned that neurological checks unwitnessed falls as there the resident may have hit er explained that if the nead during the fall that occur internally that were not a visual observation. The expected all neurological ed as per the facility dmitted to the facility on a that included dementia. sident #2 included the risk fusion and unawareness of rea was initiated on 2/4/19 after falls on 1/18/20, The interventions included, hecks after the falls on 1/10/20. In Data Set (MDS) (MD	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION	
F 600	q shift #2) and 1 of completed 4 hours check #2). The ren assessments were normal limits. An interview was conversely assessment in the fact neurological checks nurse was to complete assessment in the fact (EMR) at the follow 4, q 30 minutes x 2 and q shift x 2. Based on review of assignments and do record the following Resident #2 when review due, but were - Nurse #3 was assess was due. - Medication Technical assigned when q shift x 2. During email correst 11/23/20 at 5:17 Ph. week the Unit Manacompleting neurological services were not serviced as a service when the service were serviced as a	not completed (q shift #1 and the assessments was late by Nurse #3 (q 4 hours naining neurological completed and were all within onducted with the Director of 11/19/20 at 1:30 PM. When stility 's protocol for a she stated that the assigned ete the neurological Electronic Medical Recording frequency: q 15 minutes x q 1 hour x 4, q 4 hours x 6, the nursing schedule with occumentation in the medical staff were assigned to neurological assessments not completed: igned when q shift #1 check cian (Med Tech) #1 was nift #2 check was due. Spondence with the DON on M she indicated that during the agers were responsible for gical assessments if a med M to the resident and on the	F 60			
	assignments indica due on Saturday, 1	e nursing schedule with ted the q shift #2 check was 0/10/20, and Nurse #5 was with Med Tech #1 at that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			C 12/02/2020
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	<u> </u>	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	on 11/23/20 at 5:37 how staff knew a ne due. She stated that the resident the shift nurse if a neurologic completed during th this required communand she revealed the always occur. She adays that the shift set there were things the one of the neurologic #1 check that was desident #2's fall to 11:55 AM was review was unable to recall this neurological associated that she had this assessment was assumed it was one very busy causing the completed late. A phone interview we on 11/24/20 at 2:26	as conducted with Nurse #3 PM. Nurse #3 was asked urological assessment was t the nurse who worked with t prior informed the oncoming tal assessment needed to be eir shift. She indicated that unication between the nurses at this communication did not added that there were some elemed to be non-stop and at could get missed, such as cal assessments. The q shift ue, but was not completed for nat occurred on 10/8/20 at wed with Nurse #3. Nurse #3 why she had not completed elessment for Resident #2. t #2 that was completed 4 wed with Nurse #3. Nurse #3 not recalled with certainty why sompleted late, but she of the nights that things were the assessment to be as conducted with Nurse #5 PM. Nurse #5 reiterated	F 6			
	worked with the resi the oncoming nurse needed to be compl reported that she wa worked at the facility recollection she com	w stating that the nurse who dent the shift prior informed if a neurological assessment eted during their shift. She as an agency nurse and of for 5 weekends and to her apleted no neurological facility. Resident #2 's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			C 12/02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	l	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	completed, and the sthat indicated Nurse with Med Tech #1 will #2 when the q shift or reviewed. Nurse #5 that was the first tim Tech #1 and she had med tech rather than shift. She further recknown a neurological Resident #2. A follow up interview DON on 12/2/20 at a standard than the explainment of the properties of	iff check #2 that was not schedule with assignments #5 was working on the floor ho was assigned to Resident check #2 was due were revealed that she believed e she had worked with Med do not known that she was a had not an anurse until the end of the wealed that she had not all assessment was due for was conducted with the 10:35 AM. The DON revealed ecks were essential to be deviations from their ined that neurological checks in unwitnessed falls as there at the resident may have hit her explained that if the head during the fall that occur internally that were not a visual observation. The expected all neurological eted as per the facility on cently readmitted on 8/17/20 included cerebral infarction, dementia.	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 12/02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERI	DEEN	9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	12/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 600	area of the risk for figait/balance probler safety needs. This and reviewed on 11 included, in part, an Resident #5 's need. A post fall review not Resident #5 had an Resident #5 was for bed. He was assess A review of Resident assessment record fall at 12:30 AM reviassessments were and q shift #2). The assessments were and q shift #2). The assessments were normal limits. Based on review of assignments and do record the following Resident #5 when more due, but were - Nurse #7 was assignments and do record the following Resident #5 when more due, but were - Nurse #7 was assignments and do record the following Resident #5 when more due, but were - Nurse #7 was assignments and do record the following Resident #5 when more due, but were - Nurse #7 was assignments and do record the following Resident #5 when more due, but were - Nurse #7 was assignments and do record the following Resident #5 was assignments and do record the following Resident #5 was assignments and do record the following Resident #5 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments and do record the following Resident #6 was assignments was assignments and do record the following Resident #6 was assi	esident #5 included the focus alls related to confusion, ms, and unawareness of area was initiated on 4/29/20 //16/20. The interventions ticipating and meeting ds. Ote dated 11/19/20 indicated unwitnessed fall at 12:30 AM. and on the floor beside his sed with no injuries. In #5's neurological initiated on 11/19/20 after his ealed 2 of the 18 neurological not completed (q 4 hours #6 are remaining neurological completed and were all within the nursing schedule with ocumentation in the medical staff were assigned to neurological assessments	F 600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COMPLETED
		345509	B. WING		C 12/02/2020
	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 600	was asked who was neurological check? shift. She reported the oncoming nurse had extra time and The q 4 hour check at 7:00 AM but was with Nurse #7. Nurremembered the nuthat day told her the during her shift. She this nurse was. She that the q 4 hours check #1 on 11/20/2 completing the q 4 life Further review of the assignments and the record for Resident indicated Nurse #3 #5 on 11/20/20 at 3 hour check #6. A phone interview won 11/23/20 fall that indicated hours check #6 wereviewed with Nurse if she had conducted to completing her she had conducted to completin	ment would be missed. She aresponsible for completing a that was due at change of that this would normally fall to a unless the previous nurse completed it out of a courtesy. #6 that was due on 11/20/20 not completed was reviewed se #7 stated that she rse who reported off to her a q shift #1 check was due to explained that she noticed theck #6 was not recorded in ord, but she thought the forgotten to document it. She she completed the q shift 20 at 11:00 AM rather than nour check #6 at 7:00 AM. The neurological assessment #2 related to his 11/19/20 fall completed the q 4 hour check to AM prior to the missed q 4 are conducted with Nurse #3 PM. The neurological for Resident #2 related to his dicated Nurse #3 completed was to the prior to the missed q 4 are not completed was to the q 4 hours check #6 prior was conducted was unable to recall the q 4 hours check #6 prior	F 60		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345509	B. WING _		12/02/2020	,
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)) BE COMPLE	ETION
F 600	Continued From page	e 37	F 6	00		
F 725 SS=D	(DON) on 11/19/20 at facility 's protocol for the assigned nurse to assessment in the Ele (EMR) at the following 4, q 30 minutes x 2, and q shift x 2. A follow up interview DON on 12/2/20 at 10 that neurological chemonitor a resident for baseline. She explain were conducted after was a possibility that their head. She furth resident had hit their complications could able to be seen with a DON stated that she checks to be complet protocol. Sufficient Nursing State CFR(s): 483.35(a) (1) §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and resident safety and a practicable physical, well-being of each regresident assessments and considering the resident and considering the resident safety and a practicable physical, well-being of each regresident assessments and considering the resident safety and a considering the resident safety and a practicable physical, well-being of each regresident assessments and considering the resident safety and a considering the resident safety	r deviations from their ned that neurological checks unwitnessed falls as there the resident may have hit er explained that if the head during the fall that occur internally that were not a visual observation. The expected all neurological ed as per the facility aff (2) Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care	F7	25	12/18/2	20

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 12/02/2020
	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 725	by sufficient number types of personnel of nursing care to all resident care plans: (i) Except when waithis section, licensee (ii) Other nursing personnel of the personnel of t	acility must provide services rs of each of the following on a 24-hour basis to provide esidents in accordance with ved under paragraph (e) of d nurses; and ersonnel, including but not es. pt when waived under section, the facility must d nurse to serve as a charge of duty. It is not met as evidenced eview and staff interview, the ride sufficient staffing to assessments with vital signs redered by the physician for 1 wed for falls (Resident #1). Ed: tially admitted to the facility on exently readmitted to the with diagnoses that included believed, respiratory failure, explumonary Disease (COPD), extension (HTN), D), personal history of Attack (TIA), personal history	F 72	F-725 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this correction does not constitute an admission or agreement by the provide truth of the facts or alleged, or the correctness of the conclusions set from the statement of deficiencies. The of correction is prepared and submissolely because of the requirement ustate and federal law and to demonsthe good faith attempts by the provisimprove the quality of life of each results.	plan of vider of he orth his plan tted under strate der to
	The annual Minimul	m, and speech disorder. m Data Set (MDS) 10/21/20 indicated Resident severely impaired. He		Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAI committee team on 12/02/2020 to it the root cause of this alleged	PI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING			l .	С	
			D. WING_			1 12	2/02/2020	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT ABE	RDEEN			15 PEE DEE ROAD			
				A	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	Continued From p	page 39	F7	725				
	required extensive	e assistance of 1 with bed			non-compliance. Root cause analysis			
		ferred only once or twice with			conducted revealed that the alleged			
	the assistance of				non-compliance resulted from inadequ	uate		
					training/understanding of the staff			
	Resident #1 's ca	re plan, with a review date of			regarding sufficient staffing level			
		the focus area of the risk for			requirements.			
		t/balance problems and						
		e interventions included			For affected resident(s):			
	anticipating and meeting Resident #1 's needs. This care plan also included the focus area of a				Resident #1 no longer resides in the			
					facility.			
		lated to physical impairments. included the assistance of 2			For other residents with the potential t	o ho		
		inicidued the assistance of 2 inical lift for transfers.			affected:	o be		
	Stall allu a lilecila	illical litt for transfers.			All residents have the potential to be			
	A nursing note da	ted 11/9/20 at 10:25 AM			affected by this alleged non-compliance	ce		
	_	rse #1 indicated that staff			and as a result, the systemic changes			
		nt #1 outside on the ground in			stated below have been put in place to			
		he wheelchair had flipped			prevent any risk of affecting additional			
		e ground. The resident			residents.			
	remained in whee	lchair as it flipped. He was						
		asion on the back of his head			Facility plan to prevent re-occurrence:			
		ter. Resident #1 was taken to			On 11/23/202 the DON initiated			
		sferred back to bed via a			re-education to the nursing staff on the			
		th 2 staff assist. Vital signs were			importance of completing neuro check			
		ressure (bp) 135/81, pulse 101,			assessment, notification, and following			
		emperature 97.1, Oxygen (O2)			physician orders after a fall. The nursi	•		
		esident #1 ' s physician was a new order to monitor the			staff was also re-educated to ask the Managers, Staff Development	Jnii		
		ack of Resident #1 's head for 7			Coordinator, and/or the Director of			
		ete neurological checks			Nursing should they have any question	ns		
		ns) per facility protocol. The			or require guidance and assistance wi			
	, ,	d to be in bed watching			resident that has had an acute change			
	television.	J			Education was completed on 11/24/20			
	A nursing note da	ted 11/9/20 at 12:50 PM			On 12/02/2020 the Administrator initia	ted		
		se #1 indicated that NA #1			re-education to the Director of Nursing			
		nt #1 ' s lunch tray and informed			Staff Development Coordinator, and the			
		resident was not responding.			Scheduler regarding the need to main			
	Nurse #1 observe	ed Resident #1 who had no			sufficient nursing staffing levels to ens	ure		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION (X3) DATE SUR' COMPLETE		OMPLETED
		345509	B. WING _				C 12/02/2020
	ROVIDER OR SUPPLIER	EEN		915	REET ADDRESS, CITY, STATE, ZIP CODE 5 PEE DEE ROAD BERDEEN, NC 28315	<u>. I</u>	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	order. A review of the neurous the Electronic Medicaneurological assess completed as follows - every (q) 15 minute - q 30 minutes 2 time - q 60 minutes 4 time - q 4 hours 6 times - q shift 2 times The neurological ass 11/9/20 for Resident assessments had be A review of the vital sindicated the vital signed Resident #1 after his indicated the followir - 11/9/20 at 9:56 AM	ood pressure, or O2. o Not Resuscitate (DNR) ological assessment record in al Record (EMR) indicated ments were supposed to be seen as 4 times as 4 times as 4 times as a seen	F 7	725	that staff are able to complete require tasks such as neurological assessme and vital signs in the event of a fall. The Administrator, the Director of Nur Staff Development Coordinator, and to Scheduler will review the staffing schedaily to ensure that sufficient staffing levels will be met and will adjust as necessary. Facility plan to monitor its performance make sure that solutions are sustained A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all shifts have appropriate staffing levels to perform complete their necessary tasks. This monitoring process will take place dai 3 weeks, weekly for 3 weeks, then monthly for 3 months. The Administrator, DON, or designee report findings of the monitoring procest to the facility Quality Assurance and Performance Improvement Committee.	sing, he edule e to d: e the and ly for will ess	
	of Nursing (DON): bp - 11/9/20 at 10:30 AM 100/60, respirations pulse 92 An interview was cor 11/19/20 at 1:30 PM facility 's protocol for stated that the assign the neurological asse	A completed by the Director of 135/81 A completed by the DON: bp 20, temperature 96.4, and adducted with the DON on When asked about the reproductive median needs are to complete essment in the EMR at the q 15 minutes x 4, q 30			any additional monitoring or modificat of this plan. The QAPI Committee car modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 12/18/2020.	ion	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345509	B. WING _			C 12/02/2020
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	ye 41	F 7	725		
	shift x 2. She report assessment included the assigned NA was the nurse, but the NA the remainder of the it required a nurse 's	r x 4, q 4 hours x 6, and q ed the neurological d vital signs. She stated that s able to obtain vital signs for As were not able to complete neurological assessment as s clinical assessment. as conducted with Nurse #1				
	(an agency nurse) o Nurse #1 stated that Resident #1 at the ti approximately 9:55 at #1 fell outside in his of his head on the grabrasion the size of stated she instructed Resident #1 inside at could take his vitals.	n 11/20/20 at 11:16 AM. Is she was assigned to me of his fall on 11/9/20 at AM. She indicated Resident wheelchair and hit the back round and sustained an a quarter to his head. She d NA #1 and NA #2 to take and put him in bed, so she Nurse #1 stated that she				
	check around 10:00 normal limits. She r completed her asses physician and inform fallen and hit his hea the physician and th neurological checks	ompleted a neurological AM and these were within eported that after she essment she called the ned her the resident had ad. She provided the vitals to e physician ordered every 15 minutes per #1's medical record that				
	indicated no neurolo completed after Res reviewed with Nurse she conducted only Resident #1 on 11/9 occurred soon after a subsequent check indicated that there these assessments. explain why these neurological explain why these neurological explain why these neurological explain why these neurological explain why these after the second explain why these neurological explain e	gical assessments were ident #1 's 11/9/20 fall was #1. Nurse #1 revealed that 2 neurological checks for /20, the initial check that the fall around 10:00 AM and around 10:30 AM. She were no irregularities with Nurse #1 was unable to eurological checks she said :00 AM and 10:30 AM were				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345509	B. WING _			C 12/02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	DDE	12/02/2020
(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 ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	DATE
F 725	not in the medical rechad not completed the with vital signs that we AM, 10:45 AM, 11:30 #1 explained that she and she didn't have the neurological assesshe asked NA #1 to oprotocol. She acknow NA #1 was not able to assessments. An undated written st #1 indicated after Rechards with the could assess him took Resident #1's vanother set around 10 after she completed to continue care for othat after lunch time st #1's tray and she not so she called the num (Nurse #1 and Nurse) During an interview we 12:00 PM she reported Resident #1's fall, Not take Resident #1 in and to take his vitals. The instructed her to #1's vitals every 15 revealed that she had twice, around 10:00 Adocumented them on at the nurse's station was the normal process.	cord. When asked why she eneurological assessments ere due on 11/9/20 at 10:15 AM, and 12:00 PM Nurse got very busy that morning time to complete the rest of essments. She stated that complete the vitals per wledged that she was aware to complete the neurological attement completed by NA sident #1 's fall on 11/9/20 eded the resident in bed so a. NA #1 reported that she vitals at 10:00 AM and 0:30 AM. She indicated that he vital signs she went back ther residents. She stated she went to pick up Resident sticed he was unresponsive, ses on duty for assistance #2). With NA #1 on 11/19/20 at ed that on 11/9/20 after urse #1 told her and NA #2 aside, lay him down in bed, NA #1 stated that Nurse #1 continue to take Resident minutes after that. She if taken Resident #1 's vitals AM and 10:30 AM, and she a hard copy sheet of paper in. She explained that this less for NA documentation of access to the EMR, so they	F 7	725		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C	
NAME OF D		343509	B. WING_	OTDEET AS		12/	/02/2020	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT ABER	RDEEN		915 PEE D				
				ABERDE	EN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	Continued From page	age 43	F7	725				
		them into the EMR. NA #1						
		had taken no further vitals for						
		10:30 AM as she was very busy						
		stated that one of the NAs						
	_	that day had called off, so the						
		stated that nurses were						
	_	the residents ' vital signs. She						
		was to alleviate some of the						
		1 reported that Nurse #1 was						
		NAs had called off, but she						
		ke the vital signs anyway. NA						
		er assignment was around 25						
	residents that day	(11/9/20) and that her normal						
	assignment was a	round 15. She reported that a						
	lot of the residents	at the facility were dependent						
	on the assist of 2,	making it difficult for her and						
	NA #2 to complete	their tasks with just the 2 of						
	them. She stated	that around 10:00 AM the						
	Activities Staff beg	an assisting them with some of						
	the residents as sh	ne was also an NA and she						
	noticed that they w	vere having difficulty completing						
	their tasks with on	ly 2 of them. She explained						
	that the Activities S	Staff/NA #3 took it upon herself						
	to call her boss an	d ask if she could help NA #1						
		floor. NA #1 reported that by						
		M) she and NA #2 were already						
		sks so they were trying to make						
		ssistance of Activities Staff/NA						
		that they were prioritizing the						
		ch as incontinent care, and						
		elayed or were not completed,						
		for Resident #1. She						
		had not obtained any vital						
	_	#1 after 10:30 AM as she was						
	1	the other ones. NA #1 was						
		nformed the DON or						
		she and NA #2 were having						
		g their tasks and she stated						
	that she had not ve	erbally reported this to them						

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 44 that day as she felt it was obvious they were having difficulty because of the NA call off.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) TAG F 725 Continued From page 44 that day as she felt it was obvious they were having difficulty because of the NA call off.			345509	B. WING _			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 44 that day as she felt it was obvious they were having difficulty because of the NA call off.			EEN		915 PEE DEE ROAD	CODE	12/02/2020
that day as she felt it was obvious they were having difficulty because of the NA call off.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIA	DATE
A phone interview was conducted with the Activities Staff/NA #3 on 11/19/20 at 3:57 PM. She stated that on 11/9/20 she noticed that 1 of the NAs had called off and NA #1 and NA #2 were working "short". She indicated that she was familiar with the residents and that many of them required 2 staff for assistance so she felt that NA #1 and NA #2 needed help. She reported that she called her boss and asked her if she could assist NA #1 and NA #2 on the floor and that at around 10:00 AM she was given permission to do so. Activities Staff/NA #3 stated that she had not taken an assignment, but was helping with things like answering call lights, passing ice, and passing trays. A second interview was conducted with Nurse #1 by phone on 11/24/20 at 2:45 PM. NA #1 's interview that indicated the nurses were instructed to complete vital signs for the residents on 11/9/20 due to one of the NAs calling off was reviewed with Nurse #1. Nurse #1 revealed she was aware one of the NAs called off, but she still felt that NA #1 could obtain the vital signs for Resident #1 for her as she had many responsibilities that morning. She explained that she had a resident with a tracheostomy which required additional time to complete the necessary nursing care. She reported she provided care for this resident after Resident #1 's fall on 11/9/20 for about a 30 minute period and after that she still had blood sugar levels to obtain for her assigned residents before lunch time. During an interview with the DON on 11/19/20 at 1:30 PM the vital sign record in the EMR for	F 725	that day as she felt in having difficulty became that any as she felt in having difficulty became that are the NAs had called a working "short". She familiar with the residual required 2 staff for a #1 and NA #2 needed she called her boss a sasist NA #1 and NA around 10:00 AM sheso. Activities Staff/N taken an assignment like answering call light passing trays. A second interview who by phone on 11/24/2 interview that indicat instructed to complet on 11/9/20 due to on reviewed with Nurse was aware one of the felt that NA #1 could Resident #1 for her are sponsibilities that in she had a resident who required additional tinecessary nursing caprovided care for this she fall on 11/9/20 for a after that she still har for her assigned resident who will be signed to the still har for her assigned resident who will be still har for her assig	t was obvious they were ause of the NA call off. as conducted with the 3 on 11/19/20 at 3:57 PM. 1/9/20 she noticed that 1 of off and NA #1 and NA #2 were indicated that she was dents and that many of them esistance so she felt that NA and help. She reported that and asked her if she could a #2 on the floor and that at e was given permission to do IA #3 stated that she had not to the them was helping with things ghts, passing ice, and was conducted with Nurse #1 0 at 2:45 PM. NA #1 's ed the nurses were the vital signs for the residents are of the NAs calling off was #1. Nurse #1 revealed she is en of the NAs called off, but she still obtain the vital signs for as she had many morning. She explained that with a tracheostomy which me to complete the are. She reported she is resident after Resident #1 'about a 30 minute period and did blood sugar levels to obtain dents before lunch time. With the DON on 11/19/20 at	F	725		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED
345509	B. WING		C 12/02/2020
		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
riewed. She confirmed a were obtained only twice and 10:30 AM) after Resident. The neurological in the EMR dated 11/9/20 for dono assessments are #1 's interview that eted neurological wice (around 10:00 AM and fall were reviewed with the affirmed that these were the all assessments completed for a 11/9/20 fall. Inducted with the DON and 2/20 at 10:35 AM. They both staffing had been challenging having to use agency nurses a pust/early September 2020. Indicated that COVID-19 had are to utilize PRN (as needed) infection control policy ing their staff to work at other fulle with assignments for done of the NAs had called the Administrator and DON. The ated that the scheduler was a slots for staff who called off, always possible if the call off e a shift. Resident #1 's fall 's failure to obtain ments with vitals as ordered well as Nurse #1 's interview ew that indicated the ments with vitals were not because they were busy that	F 72	5	
		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION) TAG F 72 TAG TAG F 72 TAG F 72	A BUILDING 345509 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) F 725 F 725 F 725 F 725 F 725 F 726 F 727 F 727 F 727 F 728 F 728 F 728 F 729 F 725 F 726 F 727 F 727 F 727 F 728 F 728 F 728 F 729 F 725 F 726 F 727 F 726 F 727 F 727 F 726 F 727 F 727 F 727 F 728 F 728 F 728 F 728 F 729 F 725 F 7

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	, ,	X3) DATE SURVEY COMPLETED	
			7 20.25			С	
		345509	B. WING _		<u> </u>	12/02/2020	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 725	that if Nurse #1 and N their tasks that they s and/or the DON of thi could have found the	tasks. He further stated NA #1 couldn ' t complete hould have informed him is information so that they m additional help.	F 7	725			
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1)	g Information -(4)	F 7	32		12/18/20	
	must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categoral unlicensed nursing stresident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census.	and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed a defined under State law).					
	specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readab (B) In a prominent pla residents and visitors §483.35(g)(3) Public	ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows: le format. ace readily accessible to					
	written request, make	e nurse staffing data c for review at a cost not to					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING _			l	02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EN		9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	,	02,2020
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	\$483.35(g)(4) Facility requirements. The faposted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on review of t daily Nurse Staffing for facility failed to comple requirements on 22 or (11/01/20 through 11/1). The findings included Review of the posted from 11/01/20 through following information: - 11/01/20: The actual and unlicensed staff or census was blank 11/02/20: The actual and unlicensed staff or 11/03/20: The actual and unlicensed staff or 11/03/20: The actual and unlicensed staff or 11/04/20: The actual and unlicen	data retention cility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced the facility 's required posted orms and staff interview, the tete the posting f 22 days reviewed 22/20). daily Nurse Staffing forms find 11/22/20 revealed the I hours worked of licensed were blank. I hours worked of licensed		732	F-732 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plar correction does not constitute an admission or agreement by the provide the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This pof correction is prepared and submitted solely because of the requirement understate and federal law and to demonstrate the good faith attempts by the provider improve the quality of life of each residence. Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 12/2/2020 to identification.	n of er of blan ler te to ent.	DATE
	and unlicensed staff v - 11/06/20: The actual and unlicensed staff v - 11/07/20: The total r worked of licensed arblank 11/08/20: The total r	I hours worked of licensed vere blank. I hours worked of licensed			the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequatraining/understanding of the staff regarding the nurse staffing information requirements and posting. For affected resident(s): No residents were directly affected.		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ONDIN	<u>0. 0930-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
						С
		345509	B. WING		12	2/02/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	IUS HEALTH AT ABERDI	FFN		915 PEE DEE ROAD		
ACCONDI	OO HEAEIH AI ABERDI			ABERDEEN, NC 28315		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE
F 732	Continued From page	e 48	F 732			
	-	al hours worked of licensed	''	For other residents with the pote	antial to he	
	and unlicensed staff			affected:	eritial to be	
		al hours worked of licensed		All residents have the potential t	n be	
	and unlicensed staff			affected by this alleged non-con		
		al hours worked of licensed		and as a result, the systemic ch	•	
	and unlicensed staff	were blank.		stated below have been put in p		
	- 11/12/20: The actua	al hours worked of licensed		prevent any risk of affecting add		
	and unlicensed staff	were blank.		residents.		
		al hours worked of licensed				
	and unlicensed staff			Facility plan to prevent re-occur		
		number and actual hours		On 12/2/2020 the Administrator		
		nd unlicensed staff were		re-education to the Director of N	-	
	blank.			Staff Development Coordinator,		
		number and actual hours		scheduler regarding the daily nu		
	blank.	nd unlicensed staff were		staffing information requirement		
		al hours worked of licensed		all required areas must be filled	out.	
	and unlicensed staff			Facility plan to monitor its perfor	mance to	
		al hours worked of licensed		make sure that solutions are su		
	and unlicensed staff			A monitor sheet will be done by		
		al hours worked of licensed		Administrator, DON, or designed		
	and unlicensed staff	were blank.		monitor and ensure that all of th		
	- 11/19/20: The actua	al hours worked of licensed		daily nurse staffing information i		
	and unlicensed staff	were blank.		complete and displayed appropri	riately.	
	- 11/20/20: The actua	al hours worked of licensed		This monitoring process will take	e place	
	and unlicensed staff			daily for 3 weeks, weekly for 3 w	/eeks,	
		number and actual hours		then monthly for 3 months.		
		nd unlicensed staff were				
	blank.			The Administrator, DON, or des		
		number and actual hours		report findings of the monitoring	•	
		nd unlicensed staff were		to the facility Quality Assurance		
	blank.			Performance Improvement Com		
	During email corresp	ondence with the Director of		any additional monitoring or moon of this plan. The QAPI Committee		
		/24/20 at 3:08 PM she		modify this plan to ensure the fa		
	, , ,	d daily Nurse Staffing forms		remains in substantial compliance	-	
		ne Unit Managers (UMs).		Tomano in Substantiai compilan		
				The facility alleges compliance of	on	
	A phone interview wa	as conducted with UM (Unit		12/18/2020.		

Facility ID: 970412

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 12/02/2020		
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY OF LIST IDENTIFYING INFORMATION)			9	STREET ADDRESS, CITY, STATE, ZIP CODE 115 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020		
	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 732	that she and UM #2 completing the poste since October of 201 believed Central Sup	24/20 at 3:15 PM. She stated had not been responsible for ad daily Nurse Staffing forms 9. She indicated that she oply staff filled out the form in	F 732				
	A phone interview was Supply staff on 11/24 that her work schedule Friday 5:30 AM to 1: filled in the schedule unlicensed staff on the based on the schedule each weekday. She UM #2 used to fill out staff throughout the chad not been happed Supply staff stated the took the previous da Coordinator and she form as she was able actual hours worked was not sure who was form on weekends.	as conducted with Central 4/20 at 3:54 PM. She stated alle was Monday through 30 PM. She reported she d hours for licensed and he daily Nurse Staffing form alle when she came to work indicated that UM #1 and the actual hours worked for day. She revealed that this hing for months. Central hat each day she worked, she ys posting to the Staff filled out any blanks in the eet op pull time cards to see the of staff. She indicated she has responsible for filling in the					
	Coordinator on 11/24 that she presently was completing any portion Staffing form. She is 2020 when the facilities Central Supply staffers a posting and she fit by reviewing the time previous day. She at that the posting was	as conducted with the Staff 4/20 at 4:30 PM. She stated as not responsible for on of the posted daily Nurse reported that up until August by had a COVID-19 outbreak, brought her the previous day lled in the blanks on the form becards for staff from the becknowledged her awareness supposed to be updated so current, rather than being					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 12/02/2020
	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION
F 732	updated on the folloalready been taken explained that wher occurred, she was gresponsibilities that staffing agencies to schedule, so she will blanks on the poste when Central Supply previous days posti responsibility at this forms in a binder who Central Supply staff UM #1, UM #2, and form needed to be staff throughout the filling in the blanks or responsibilities. The that this task had not forms were consisted. A phone interview won 11/30/20 at 3:00 she had not observe Staffing form until the purposes of this sur they were consisted that the former DON 2020 and she becampermanent DON she that she had many upast couple of month that this form was a naccordance with the During an interview 12/2/20 at 10:35 AM noticed that the possible staffing agents with the During an interview 12/2/20 at 10:35 AM noticed that the possible staffing agents with the During an interview 12/2/20 at 10:35 AM noticed that the possible staffing agents with the During an interview 12/2/20 at 10:35 AM noticed that the possible staffing agents with the properties of the province of the province staffing agents with the province staffing agents with the province staffing agents agents with the province staffing agents agents agents with the province staffing agents	wing day after the posting had down. The Staff Coordinator in the COVID-19 outbreak given additional included coordinating with fill in holes in the staff as no longer filling in the d daily Nurse Staffing form by staff brought her the ing. She reported that her is time was keeping all of these inent hey were given to her by it. She indicated that she told Central Supply staff that the completed by them or by floor day as she was no longer on the form due to additional the Staff Coordinator revealed on the ently incomplete. Was conducted with the DON PM. The DON revealed that the ently incomplete. Was conducted with the DON PM. The DON revealed that the ently incomplete. She explained in left the facility in September me interim DON and then ortly thereafter. She indicated new responsibilities over the this causing her not to notice ot being completed in	F 73		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		7 55.25			С
	345509	B. WING _			12/02/2020
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COL 915 PEE DEE ROAD ABERDEEN, NC 28315)E	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
responsibilities that w the form was complet regulations.	was a miscommunication on yould be corrected so that ted in accordance with the	F 7			
SS=D CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not resident-identifiable to (ii) The facility may reresident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical research (i) Medical research (ii) In accordance with a resident must maintain medical that are- (i) Complete; (ii) Accurately documing (iii) Readily accessible (iv) Systematically orgested (iv) Systematically orgested (iv) The facall information contain regardless of the form records, except when (i) To the individual, or	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;		942		12/18/20

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 12/02/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	12/02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 842	activities, judicial and law enforcement pur purposes, research pur medical examiners, f a serious threat to he by and in compliance §483.70(i)(3) The fact record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The medici of the record review of the record of the record reco	violence, health oversight administrative proceedings, poses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted with 45 CFR 164.512. Cility must safeguard medical gainst loss, destruction, or I records must be retained required by State law; or are date of discharge when ent in State law; or are after a resident reaches e law. Cedical record must containion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and fucted by the State; e's, and other licensed se notes; and logy and other diagnostic equired under §483.50. T is not met as evidenced riew and staff interview, the	F 84	F-842	
	who fell and sustaine	ment neurological nedical record for a resident ed a head injury. This was eviewed for falls (Resident		This plan of correction constitutes a written allegation of compliance. Preparation and submission of this p	lan of

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		E SURVEY IPLETED
		345509	B. WING			C
NAME OF DE	ROVIDER OR SUPPLIER	343303		STREET ADDRESS, CITY, STATE, ZIP CODE		2/02/2020
NAIVIE OF PI	ROVIDER OR SUPPLIER				=	
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 OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	Continued From page	e 53	F 84	12		
	#1).			correction does not constitute	an	
	,			admission or agreement by the		
	The findings included	l:		the truth of the facts or alleged	•	
				correctness of the conclusions	set forth	
		ally admitted to the facility on		on the statement of deficiencie	es. This plan	
		ently readmitted to the		of correction is prepared and s		
		ith diagnoses that included		solely because of the requiren		
		bleed, respiratory failure,		state and federal law and to de		
	Chronic Obstructive Pulmonary Disease (COPD), the good faith attempts by the pro		•			
	heart disease, hypert			improve the quality of life of ea	ach resident.	
	hyperlipidemia (HLD)	ttack (TIA), personal history		Root Cause:		
		and speech disorder.		The Administrator and the Dire	actor of	
	or cerebral illiarction,	and specon disorder.		Nursing discussed with the ID		
	The annual Minimum	Data Set (MDS)		committee team on 12/02/202		
		0/21/20 indicated Resident		the root cause of this alleged	,	
	#1 's cognition was s	severely impaired.		non-compliance. Root cause a	analysis	
				conducted revealed that the a	lleged	
	A nursing note dated			non-compliance resulted from		
		#1 indicated that staff		training/understanding of the s		
		1 outside on the ground in		regarding required documenta	ition	
		wheelchair had flipped		necessary following a fall.		
	backward onto the gr			F #		
		air as it flipped. He was		For affected resident(s):	in the	
		on on the back of his head Resident #1 was taken to		Resident #1 no longer resides facility.	iii iiie	
	his room and transfer			lacility.		
		staff assist. Resident #1		For other residents with the po	ntential to be	
		pain or discomfort and no		affected:	otoritial to bo	
	-	ns were obtained and were		All residents have the potentia	ll to be	
		Resident #1 ' s physician		affected by this alleged non-co		
		e a new order to monitor the		and as a result, the systemic of		
		of his head for 7 days and to		stated below have been put in	place to	
	complete neurologica	al checks per facility protocol.		prevent any risk of affecting ac residents.	dditional	
		logical assessment record in				
		al Record (EMR) indicated		Facility plan to prevent re-occi		
	neurological assessm completed as follows	nents were supposed to be		On 11/23/2020 the Director of initiated re-education to the lic	-	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	PLE CONSTRUCTION G		ATE SURVEY MPLETED
		345509	B. WING			C 1 2/02/2020
	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	•	1102/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	- every (q) 15 minu - q 30 minutes 2 tin - q 60 minutes 4 tin - q 4 hours 6 times - q shift 2 times The neurological as 11/9/20 for Resider had been complete A phone interview on 11/20/20 at 11:1 she was assigned this fall with head in she spoke with the informed her that Rhis head. She report monitoring of the reassessments per famedical record that assessments were s 11/9/20 fall was reflected that she check for Resident check that occurred 10:00 AM and a su AM. She indicated irregularities with the was unable to explaneurological check not in the medical record with Resistated that she was (Nurse #1) on 11/9/his head. She indicated accordance with the	tes 4 times nes nes nes nes nes nes nes nes nes n	F 8-	nurses on the importance of and documenting neuro che assessment, notification, are physician orders after a fall, was completed on 11/24/20 Facility plan to monitor its permake sure that solutions are A monitor sheet will be done Administrator, DON, or desimonitor and ensure that the documentation has been confollowing a fall. This monitor will take place daily for 3 weeks, then monthly for 3 weeks, then monthly for 1 monitor to the facility Quality Assurated Performance Improvement any additional monitoring or of this plan. The QAPI Commodify this plan to ensure the tremains in substantial comparts. The facility alleges compliant 12/18/2020.	ecks, and following the . Education . Educ	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING				02/2020
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315	12.7	02/2020
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	as it allowed all staff to see if there were a assessment that coul neurological injury. During an interview w (DON) on 11/19/20 at the facility 's protocostated that the assign and document neurol EMR at the following minutes x 4, q 30 min hours x 6, and q shift assessment record in Resident #1 that indice been completed after reviewed with the DO which she stated she assessments after Rereviewed with the DO Nurse #1 should have neurological assessment facility protocol. A follow up interview DON on 12/2/20 at 10 that neurological chemonitor a resident for baseline. She explain injury there could be that were not able to observation. She state the neurological asses who worked with the monitor the resident for the state of the resident for t	se neurological nedical record. She cumentation was important who worked with the resident ny changes in the d be indicative of a with the Director of Nursing at 1:30 PM when asked about a for neurological checks she need nurse was to complete ogical assessments in the frequency: every (q) 15 nutes x 2, q 1 hour x 4, q 4 x 2. The neurological at the EMR dated 11/9/20 for cated no assessments had at his 11/9/20 fall was and this 11/9/20 fall was and this 11/9/20 fall was and the properties of the documented the nents in the medical record was conducted with the coast AM. The DON revealed can be seen with a visual ted that documentation of assments allowed all the staff	F	842			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D CONSTRUCTION (X3) D CONSTRUCTION (X4) D CONSTRUCTION (X5) D CONSTRUCTION (X6) D C		(X3) DATE COMP	SURVEY LETED		
NAME OF B		345509	B. WING _		12/	02/2020
NAME OF PE	ROVIDER OR SUPPLIER			FREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EEN		BERDEEN, NC 28315		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ITE	(X5) COMPLETION DATE	