**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

ACCORDIUS HEALTH AT GREENSBORO, LLC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1201 CAROLINA STREET
GREENSBORO, NC  27401

**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 000</td>
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<td>INITIAL COMMENTS</td>
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<tr>
<td>F 658</td>
<td>SS=D</td>
<td>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</td>
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The survey team entered the facility on 7/8/21 to conduct a complaint investigation in conjunction with a follow up survey and exited on 7/14/21. Event ID # DKYX11. 7 of the 8 complaint allegations were not substantiated, however allegations resulted in deficiencies F658 and F571. The Statement of Deficiencies was amended on 8/3/21 at tag F571 and tag F658.

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F 658</td>
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<td>7/23/21</td>
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Resident #1 discharged from facility on 6/19/2021, prior to complaint survey. Prior to discharge there was no negative impact on Resident #1.

An audit of all other resident medications was completed to identify any other residents who may be receiving medication from a specialty pharmacy, home or medication not provided by the facility pharmacy. Audit also included any medication not given by a licensed nurse or medication aide. No other residents were identified as affected.

Root cause identified the following issues; a family member who refused to store specialty medication in medication cart and refused to allow staff to administer,

Resident #1's admission Minimum Data Set assessment dated 6/17/21 revealed he had severe cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, toileting, and hygiene. Resident #1 could eat independently with set up assistance. He was coded for use of supplemental oxygen at 6 liters per minute via nasal cannula.

Electronic Signature

Laboratory Director or Provider/Supplier Representative's Signature

Title

Date

08/07/2021
Resident #1’s admission orders dated 6/11/21 revealed he had an order for Ofev Capsule 150 MG (Nintedanib Esylate) to be given twice daily (9:00 AM, 6:00 PM) for chronic pulmonary hypertension. The order notated ‘Family to provide’ in the comment section of the order.

Resident #1’s Medication Administration Record (MAR) dated 6/12/21 revealed nurse documentation that the Ofev Capsule medication was awaiting pharmacy’s arrival. Nurse documentation on the MAR revealed the Ofev Capsule medication was administered 6/13/21 through 6/19/21 twice daily but noted exceptions on 6/13/21 and 6/14/21 6:00 PM doses were not given. Nurses’ notes indicated the doses were not given on 6/13/21 and 6/14/21 because the medication was not available.

Resident #1’s progress notes revealed no documentation that the Ofev Capsule medication was brought in by an outside source or reconciled by the nursing staff or the facility pharmacy. There were also no progress notes that showed the nurses observed the family member administered the medication to the resident.

During an interview on 7/8/21 at 3:07 PM, the Admissions Coordinator revealed she had communicated with Resident #1’s family member prior to admission and discussed the Ofev Capsule medication. She stated she informed the family member over the phone that the facility’s pharmacy was unable to provide the medication and it would need to be brought in by the family member. The facility could not obtain the medication from another pharmacy. The Admissions Coordinator also revealed the family specialty medication that was not verified by facility staff and lack of communication from Nurses to Director of Nursing or Administration that family was not allowing storage or dispensing of medication. Education was provided on 7/12/2021 to all licensed nurses and medication aides by the Director of Nursing regarding procedures to identify medication prior to administration, process for accepting and dispensing a specialty medication not provided by facility pharmacy and requirement that all medication in facility must be dispensed by licensed nurses and/or medication aides.

Medication audit will be completed weekly for 4 weeks of all new admissions to check for any medication from an outside specialty pharmacy. Audit will identify any specialty medications and then confirm identification of medication, storage of medication and dispensing by licensed nurses/medication aides. Audits will be completed by the Director of Nursing. After 4 weeks audits will be completed monthly for the next 2 months or until compliance is achieved.

Results of audits will be summarized and presented by the Director of Nursing at the Monthly Quality Assurance committee Meeting. Any issues or trends identified will be addressed by the Committee as they arise and the plan will be revised to ensure continued compliance.
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<td>member agreed to bring in the medication and provide it to Resident #1’s nurse to store and dispense.</td>
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<td>During an interview on 7/8/21 at 12:35 PM, Nurse #1 revealed she was the admitting nurse for Resident #1 on 6/11/19. She stated the family member expressed the Ofev Capsule medication costed too much and insisted on giving it to Resident #1 instead of the nurses. Nurse #1 revealed she explained to the family member that the medication could be locked inside the medication cart for safe storage and dispensing. Nurse #1 indicated when the family member refused to give the medication to the facility, she then explained to the family member the nurses would have to observe her giving the Ofev Capsule medication to the resident. Nurse #1 revealed she had observed the family member administering the medication to Resident #1 during his stay and documented in the MAR as ‘given’. Nurse #1 further revealed she never looked at the medication bottle or asked to check the label to reconcile the correct medication, frequency, and dose.</td>
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<td>The nurse that didn’t sign the MAR on 6/11/21 for the 6:00 pm dose was not available for interview. A request was made to the Director of Nursing (DON) for contact information for the agency nurses who provided care for Resident #1 from 6/12/21 through 6/19/21. The contact information for the agency nurses was not provided. Attempts to interview the additional nurses that cared for Resident #1 were unsuccessful.</td>
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<td>During a phone interview with the family member of Resident #1, on 7/8/21 at 10:10 AM she revealed the Ofev Capsule medication was for</td>
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her father's chronic lung disease and the facility never asked her for the medication upon admission or the following days. The family member stated the medication was to be taken daily and she was at the facility every day to give it to Resident #1. On day 5 of Resident #1’s stay, the family member stated the nurse asked her where the medication was located and were told the bottle was in his belongings when he was admitted from the hospital on 6/11/21. The family member revealed Resident #1 takes the medication once daily instead of twice because it makes him sick and his pulmonologist was aware. The family member further stated that the nurses would ask if the medication was given and did not observe her giving the medication to Resident #1 during his stay.

During an interview on 7/8/21 at 1:05 PM, the DON revealed she was not employed at the time of Resident #1’s stay at the facility and was not aware this situation had occurred with Resident #1. She revealed there were no policies or procedures instituted for a family member to administer medications at the facility, however there were policies in place for resident self-administration of medications. The DON indicated her expectations for an occurrence like this was the nurses were to observe the family member administer the medication each time and document in the MAR as well as a correlating progress note that indicated the family member gave the medication.

During an interview on 7/9/21 at 2:10 PM, the physician revealed he was not aware that the family member was giving the Ofev Capsule medication to the resident or that it was given once a day instead of twice a day.
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345014

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

C 07/14/2021

(X4) ID PREFIX TAG

(X5) COMPLETION DATE