PRINTED: 11/02/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345509	B. WING _			1	30/2021
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP C 915 PEE DEE ROAD ABERDEEN, NC 28315	CODE	1 00/	00/2021
(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 ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000		3.73, Emergency : ID# EKRC11.	F 0	00			
		complaint investigation od from 9/27/21 through EKRC11.					
F 550 SS=D	2 of the 2 complaint a substantiated. Resident Rights/Exer CFR(s): 483.10(a)(1)	cise of Rights	F 5	50			10/26/21
	self-determination, ar	Rights. ght to a dignified existence, nd communication with and nd services inside and cluding those specified in					
	with respect and digr resident in a manner promotes maintenand	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and					
APODATORY	access to quality care severity of condition, must establish and m practices regarding to provision of services	cility must provide equal e regardless of diagnosis, or payment source. A facility naintain identical policies and ransfer, discharge, and the under the State plan for all		TITLE			(X6) DATE

Electronically Signed 10/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN	,	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 00/00/2021
(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 APPROPF DEFICIENCY)	BE COMPLETION
F 550	rights as a resident of or resident of the Un §483.10(b)(1) The faresident can exercise interference, coercio from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be suppexercise of his or her subpart. This REQUIREMEN' by: Based on record revesident interviews, the dignity by not providing injection (Resident #assisting a dependent (Resident #59). This reviewed for dignity. The findings included 1. Resident #215 was 3/17/2020 with diagrant diabetes.	of Rights. right to exercise his or her of the facility and as a citizen ited States. cility must ensure that the e his or her rights without n, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her corted by the facility in the r rights as required under this T is not met as evidenced views, observations, staff and he facility failed to promote ng privacy during an insulin 215) and by standing while nt resident during a meal s was for 2 of 2 residents d: s admitted to the facility loses that included type two	F 550	F-550 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pl correction does not constitute an admission or agreement by the provice the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This of correction is prepared and submitted solely because of the requirement unstate and federal law and to demonst the good faith attempts by the provides	der of th plan ed der rate er to
	(MDS) dated 9/8/202 mildly cognitively imp behaviors. The resid	st recent Minimum Data Set 21 indicated the resident was baired and had no moods or ent required extensive ities of daily living (ADL) and		improve the quality of life of each resi Root Cause: The Administrator and the Director of	ueni.

A. BUILDING A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN ACCORDIUS HEALTH AT ABERDEEN (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 2 received insulin injections 7 out of 7 days during the assessment period. A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Continued From page 2 received insulin injections 7 out of 7 days during the assessment period. A. BUILDING NURSING (DON) discussed with the IDT QAPI committee team on 9/30/2021 to	(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 TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 2 received insulin injections 7 out of 7 days during STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Nursing (DON) discussed with the IDT	•	
ACCORDIUS HEALTH AT ABERDEEN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 2 F 550 received insulin injections 7 out of 7 days during P15 PEE DEE ROAD ABERDEEN, NC 28315 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Nursing (DON) discussed with the IDT	0/2021	
ACCORDIUS HEALTH AT ABERDEEN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 2 received insulin injections 7 out of 7 days during ABERDEEN, NC 28315 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Nursing (DON) discussed with the IDT		
ABERDEEN, NC 28315 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 2 received insulin injections 7 out of 7 days during ABERDEEN, NC 28315 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Nursing (DON) discussed with the IDT		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 2 received insulin injections 7 out of 7 days during PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Nursing (DON) discussed with the IDT		
received insulin injections 7 out of 7 days during Nursing (DON) discussed with the IDT	(X5) COMPLETION DATE	
the assessment period. QAPI committee team on 9/30/2021 to		
identify the root cause of this alleged		
On 9/28/2021 at 8:08 AM Nurse #4 was observed non-compliance. Root cause analysis		
asking Resident #215 to lift her gown so she could administer insulin in her abdomen. The conducted revealed that the alleged non-compliance resulted from inadequate		
resident was sitting on the side of her bed, visible training/understanding of the nursing staff		
from the door and visible to her roommate. Nurse regarding resident rights and that privacy		
#4 did not shut the door or pull the privacy curtain must be given during injections and staff		
prior to administering insulin. The resident's lower must be seated while assisting a resident		
abdomen and her incontinent brief were exposed during a meal.		
during the insulin administration.		
For affected resident(s):		
An interview was conducted with Resident #215		
on 9/28/2021 at 12:18 PM. She stated she did not Resident #215 is ensured privacy during		
want to "advertise". She wanted the nurse to close the door and pull the privacy curtain prior to insulin injections and resident #59 is assisted during mealtimes with a staff		
administering insulin in her abdomen. When member in a seated position.		
asked if the nurses routinely provided privacy		
during insulin administration, she stated some For other residents with the potential to be		
nurses did and others did not. affected:		
On 9/29/2021 at 11:21 AM an interview was On 10/21/2021 an audit (title: f-550) of all		
conducted with Nurse #4. She stated she typically residents was done by the Director of		
does close the door and pull the curtain for Nursing to identify all residents that		
privacy, but on that occasion, she just forgot. receive injections were provided privacy		
An interview was conducted with the Director of and that all residents that are dependent for meals were assisted by a staff		
An interview was conducted with the Director of Nursing (DON) and the Administrator on for meals were assisted by a staff member in a seated position. No other		
9/30/2021 at 12:39 PM. Both stated they expect issues were noted during audit. The		
staff to provide privacy and promote dignity for all systemic changes stated below have been		
residents. put in place to prevent any risk of affecting		
2. Resident #59 was admitted on 9/4/20 with additional residents.		
cumulative diagnoses of Diabetes and Dementia.		
Facility plan to prevent re-occurrence:		
Review of Resident #59's revised care plan dated		
4/29/21 indicated she was dependent on staff to To protect residents from similar		
eat her meals. occurrences, on 10/13/2021 The Director of Nursing, Staff Development		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				SURVEY LETED
		345509	B. WING _				30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		91	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	<u> </u>	50/2021
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Resident #59's annual dated 9/13/21 indicate impairment and code assistance for eating. In an observation on Resident #59 was sittle standing at the bedsid Observed was a chain stated she normally dassisting a resident with important to be at eye Resident #59. In an interview on 9/3 Administrator stated in indicate in the state of the stat	al Minimum Data Set (MDS) ed severe cognitive d for extensive physical 9/28/21 at 8:50 AM, ting up in bed with Nurse #3 de feeding the resident. r in the room. Nurse #3 loes not stand while vith eating because it was	F	550	Coordinator, and Unit Manager initiated re-education to all nursing staff regarding resident rights and the need to have privacy during injections and to assist with meals in a seated position. All nursing staff education will be completed by 10/25/2021. Any nursing employee that did not receive training by this date will receive it prior to the next shift schedule. Facility plan to monitor its performance make sure that solutions are sustained. A monitor sheet will be done by Administrator, DON, or designee to monitor and ensure that all residents the receive injections have the appropriate privacy and that all residents who requi assistance with meals are assisted by staff in a seated position. This monitoring process will take place weekly for 4 weethen monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee 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	ng vith t ed. to at re ng eks	
F 584 SS=B		ble/Homelike Environment (7)	F 5	584	10/26/2021		10/26/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
		345509	B. WING		C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		915 PEE DEE ROAD		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 584	Continued From pag	ge 4	F 584	1		
	but not limited to rec supports for daily livid. The facility must pro §483.10(i)(1) A safe, homelike environme use his or her person possible. (i) This includes ensine receive care and serphysical layout of the independence and did (ii) The facility shall of the protection of the or theft. §483.10(i)(2) House services necessary fand comfortable interested in good condition; §483.10(i)(3) Clean in good condition; §483.10(i)(4) Private resident room, as sponsored in all areas; §483.10(i)(6) Comform levels. Facilities initialized.	ight to a safe, clean, nelike environment, including seiving treatment and ing safely. vide- , clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can roices safely and that the e facility maximizes resident loes not pose a safety risk. exercise reasonable care for resident's property from loss keeping and maintenance to maintain a sanitary, orderly,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '			(3) DATE SURVEY COMPLETED	
		345509	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	0	9/30/2021	
TO WILL OF TH	NOVIDER OR GOLL EIER			915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 584	Continued From page	e 5	F 58	4			
	sound levels. This REQUIREMENT by:	maintenance of comfortable is not met as evidenced					
	Based on record rev interviews, the facility rooms were in good r #415, and #205) and Terminal Air Condition #301, #303, #305 and 16 resident rooms reclean, and homelike of the findings included 1) On 9/27/21 at 10:5 room 412 revealed dawall to the right of the sheetrock. Observations were controlled the Maintenance Directly He observed the area indicated he was not wall. He acknowledge attention and would be the Administrator and the sheetrock.	ico AM, an observation of amage to the plaster of the ewindow, exposing conducted during a round with ector on 9/29/21 at 11:10 AM. It is a of exposed sheetrock and aware of the damage to the end the area did require the repaired.		F-584 This plan of correction constitutes written allegation of compliance. Preparation and submission of the correction does not constitute an admission or agreement by the pthe truth of the facts or alleged, of correctness of the conclusions seen the statement of deficiencies. Of correction is prepared and subsolely because of the requirement state and federal law and to demand the good faith attempts by the presimprove the quality of life of each Root Cause: The Administrator and the Director Nursing discussed with the IDT Committee team on 9/30/2021 to the root cause of this alleged non-compliance. Root cause and conducted revealed that the allegations are considered to the root cause of the reconsidered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause and conducted revealed that the allegations are considered to the root cause are considered to the root cause and conducted to the root cause are considered to the root cause and conducted to the root cause are considered to the root cause and conducted to the root cause are conducted to the root cause and	rovider of or the et forth This plan omitted of under constrate ovider to resident. or of QAPI identify		
	was important for the repaired and homelik 2) On 9/27/21 at 11:0	0 AM, an observation of e top left dresser drawer		non-compliance resulted from ina training/understanding of the mai staff regarding maintaining a safe/clean/comfortable/homelike environment. For affected resident(s):			
	Observations were co	onducted during a round with ector on 9/29/21 at 11:15 AM.		Resident room #s 412, 414, 415, were repaired on 9/30/2021 by the Maintenance Director. Resident r	ie		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		X3) DATE SURVEY COMPLETED	
					С		
		345509	B. WING _		09/30	0/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABEF	RDEEN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 584	Continued From p	age 6	F 5	84			
	dresser on the left	nissing top-drawer front to the side of the room and stated he as missing but would address		301, 303, 305, and 308 air filters were cleaned on 9/30 Maintenance Director.			
		and Director of Nursing were 0/21 at 9:15 AM, and stated it		For other residents with the affected:			
	was important for repaired and home	the environment to be well elike.		A 100% audit (title: f-584) w by the Maintenance Director to ensure that all rooms we repair and that all air condit	Director on 9/30/2021 ms were in good		
	room 415 revealed	1:15 AM, an observation of d the dresser to the right side of sing the drawer front of the 2nd		were clean. No other occur noted. The systemic changes state been put in place to preven affecting additional resident	rences were ed below have t any risk of		
	Maintenance Direc	e conducted with the ctor on 9/29/21 at 11:20 AM. He ing second drawer front to the		Facility plan to prevent re-o			
	acknowledged knowledged knowledged had the dresse	nt side of the room. He bying it was missing and stated r part in his office but "just to replace it" but would address		To protect residents from si occurrences, on 9/30/2021 Administrator completed rethe Maintenance Director a Maintenance Assistant rega	the -education to nd the		
	The Administrator interviewed on 9/3	and Director of Nursing were 0/21 at 9:15 AM, and stated it		maintaining rooms in good maintaining clean air condit	repair and tioner filters.		
	repaired and home 4. On 9/27/21 at 9	:55 AM, an observation of room		Facility plan to monitor its p make sure that solutions ar	e sustained:		
		valls were patched in multiple opeared to be putty in inting.		A monitor sheet will be done Administrator, DON, or des monitor and ensure that all are in good repair and that	ignee to resident rooms		
	the Maintenance I PM. He observed 205. He acknowle	e conducted during a round with Director on 9/30/21 at 12:00 the areas of patching in room edged room 205 did require		conditioning filters remain of monitoring process will take for 4 weeks then monthly for	elean. This e place weekly or 4 months.		
	painting and the fa	cility recently hired an assistant		Any issues during monitorir	ng will be		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345509	B. WING			C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	DDE	03/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	5.75
F 584	to help get caught up The Administrator and interviewed on 9/30/2 was important for the repaired and homelik 5. On 9/21/21 at 9:59 Packaged Thermal Ai in rooms 301, 303, 30 amount of visible dus Observations of room were conducted durin Maintenance Director He stated normally al monthly "but for some those rooms and forg stated he had to amb get to his office in the cleaning the PTAC fill oversight. He stated f assistant to help get of maintenance. The Administrator and	on repairs. d Director of Nursing were 1 at 9:15 AM, and stated it resident rooms to be well e. AM, an observation of r Conditioning (PTAC) units 5 and 308 had a large t on the filters.	F 5	addressed immediately. The Administrator, DON, or desireport findings of the monitor to the facility Quality Assura Performance Improvement of any additional monitoring or of this plan. The QAPI Commodify this plan to ensure the tremains in substantial compact The facility alleges compliant 10/26/2021	gnee will uring process nce and Committee f modification mittee can ne facility liance.	or
F 585 SS=D	was important for the repaired and homelik Grievances CFR(s): 483.10(j)(1)-194.8483.10(j)(1) The res grievances to the faci that hears grievances reprisal and without for	resident rooms to be well e. (4)	F 5	85		10/26/21

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	7 30/33/2021
(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 APPROPE DEFICIENCY)	BE COMPLETION
F 585	furnished as well as a furnished, the behavior residents, and other facility stay. §483.10(j)(2) The residential facility must make provided facility must make provided facility must make provided facility must make provided for the resident. §483.10(j)(3) The facility facility for the resident. §483.10(j)(4) The facility facility for the resident. §483.10(j)(4) The facility for the resident. The grievance policy to end fall grievances regard contained in this paraprovider must give a to the resident. The grievance facility of the right to (meaning spoken) or grievances anonymo of the grievance anonymo of the grievance offician be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written de grievance; and the confidence in the policy filed, that is, the policy filed f	reatment which has been that which has not been for of staff and of other concerns regarding their LTC sident has the right to and the compt efforts by the facility to be resident may have, in paragraph. Sility must make information ance or complaint available sility must establish a may request, the copy of the grievance policy grievance policy must sindividually or through the locations throughout the file grievances or ally in writing; the right to file usly; the contact information ial with whom a grievance policy enail and business email) and business phone to expected time frame for the grievance; the right cision regarding his or her	F 58	5	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		DATE SURVEY COMPLETED	
		345509	B. WING _			C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP COE 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 585	(ii) Identifying a Griev responsible for overs receiving and tracking conclusions; leading by the facility; maintal information associate example, the identity grievances submitted written grievance decoordinating with state necessary in light of state (iii) As necessary, take prevent further potentight while the alleged investigated; (iv) Consistent with § reporting all alleged vabuse, including injuring and/or misappropriation anyone furnishing se provider, to the admit as required by State (v) Ensuring that all vinclude the date the summary statement of the steps taken to invisummary of the perting regarding the resider as to whether the grieconfirmed, any correct taken by the facility and the date the writt (vi) Taking appropriation accordance with State of the residents' right or if an outside entity	and advocacy system; rance Official who is eeing the grievance process, g grievances through to their any necessary investigations ining the confidentiality of all ed with grievances, for of the resident for those anonymously, issuing eisions to the resident; and ee and federal agencies as especific allegations; sting immediate action to tial violations of any resident diviolation is being 483.12(c)(1), immediately violations involving neglect, ries of unknown source, on of resident property, by rices on behalf of the nistrator of the provider; and law; written grievance decisions grievance was received, a of the resident's grievance, a nent findings or conclusions it's concerns(s), a statement evance was confirmed or not citive action taken or to be a result of the grievance, en decision was issued;	F 5	85			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
		345509	B. WING _			C 09/30/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CC		03/00/2021
				915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERI	DEEN		ABERDEEN, NC 28315		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 585	confirms a violation rights within its area (vii) Maintaining evi result of all grievand 3 years from the iss decision. This REQUIREMENDY: Based on staff and interviews and recoprovide a written not resolution to the resumember. This was at #24 and Resident # for grievances. The 1. Resident #41 was cumulative diagnos and anxiety. Review of Resident record (EMR) indicated in the interview of Resident #41's RP communication, cus #41's care. The form follow up phone cal informing her of the grievance. The form written grievance regrievance form was staff acknowledging resolved.	for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance AT is not met as evidenced Responsible Party (RP) rd review, the facility failed to obtification with the grievance sident, RP and/or family for 3 (Resident #41, Resident #60) of 3 residents reviewed findings included: s admitted on 9/9/20 with es of dysphagia, contractures #41's electronic medical ated he had an RP listed as contact. Ince dated 2/2/21 read had concerns regarding stomer service and Resident medical ated as the resolution, a laws conducted with the RP results/resolution of her and did not indicate a verbal or esolution was provided. The salso not signed by any facility of the grievance had be	F	F-585 This plan of correction const written allegation of complia Preparation and submission correction does not constitut admission or agreement by the truth of the facts or alleg correctness of the conclusio on the statement of deficient of correction is prepared and solely because of the requires state and federal law and to the good faith attempts by the improve the quality of life of Root Cause: The Administrator and the Discontinuous discussed with the I committee team on 9/30/202 the root cause of this alleger non-compliance. Root cause conducted revealed that the non-compliance resulted fro training/understanding of the Service Director regarding the requirement of written notifications are resolution to the requirement of written notifications.	of this plan of the an the provider of ped, or the ons set forth cies. This plan d submitted ement under demonstrate the provider to each resident. Director of IDT QAPI 21 to identify de analysis alleged om inadequate e Social the cation of the	
	In an interview on 9	1/29/21 at 4:32 PM, the Social			cation of the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION (X3) DATE COMP		SURVEY LETED
		345509	B. WING			1	30/2021
NAME OF P	ROVIDER OR SUPPLIER	0.000		STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 09/	30/2021
TVAINE OF T	TO VIDER OR OUT FIER				E DEE ROAD		
ACCORDI	US HEALTH AT ABERD	EEN					
				ADER	DEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From pag	ye 11	F 5	85			
	grievance officer. Sh	ne stated she and the					
		or listed in the grievance		Fo	or affected resident(s):		
	i i	ance investigations together			,		
		erns. The SW stated she		W	ritten notification of the grievance		
	_	ed verbally with the individual			solution was sent to the resident, RP	,	
		evance and asked if they		an	d or family member as indicated for		
	wanted a copy of the	grievance. She stated she		Re	esident #41, #24, and #60 by the Soc	cial	
	was not aware until	9/28/21 that a written		W	orker. Completed by 10/23/2021.		
	grievance response	was required.					
				Fo	or other residents with the potential to	be	
	•	riew on 9/30/21 at 11:41 AM,		aff	fected:		
		tated she did not recall ever					
	receiving anything in				audit was done by the social worke	r for	
	_	ot recall being offered a			grievances in the past 6 months.		
	written grievance res	solution.			ompleted by 10/23/2021. Audit revea		
		00/04 1 4 47 DM II			Iditional individuals were affected. As	s a	
		30/21 at 1:47 PM, the		I .	sult, a written notification of the		
		ON stated it was their		-	ievance resolutions was sent to the		
		n grievance resolution be			sident, RP, and or family member as		
	provided to the party	that initiated the grievance.			dicated for any that were not previou ovided. The systemic changes stated	- 1	
	2 Pecident #24 was	admitted on 2/4/20 with a			elow have been put in place to preve		
		oral Vascular Accident.			risk of affecting additional resident		
	alagricolo di a corol	rai vaccaiai / toolacht.		411	y non or anoding additional reducing	J.	
	Review of a grievand	ce dated 4/20/21 read		Fa	acility plan to prevent re-occurrence:		
		y member was concerned					
		ne in function. A care plan		То	protect residents from similar		
	-	eted with Resident #24's		ос	currences, on 9/30/2021 the		
	family to discuss his	expected continued decline		Ad	dministrator completed re-education	to	
	and prognosis. The	form indicated the family		the	e Social Service director regarding th	ne l	
	member received ve	rbal grievance resolution and		red	quirement of providing written		
	was signed by the A	dministrator. The form did not			tification of the grievance resolution		
	•	nted evidence that the family			e resident, RP, and or family membe	r	
	member received a	written grievance resolution.		ev	en if verbally decline.		
		ce dated 6/21/21 read			acility plan to monitor its performance		
		y member went to the facility		ma	ake sure that solutions are sustained	15	
		s hair and was unable to gain					
	access by ringing the	e door bell or by phone. The		A i	monitor sheet will be done by the		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 585	form read the recept the time he attemptered the family mem grievance resolution. Social Worker. The documented evidence received a written grievance on interview on 9/ stated she was the first stated she and the coin the grievance con investigations togeth. The SW stated she everbally with the indigrievance and asked grievance. She stated 9/28/21 that a written required. A telephone interview at 11:00 AM with Residence a message. In an interview on 9/ Administrator and Dexpectation a written provided to the party 3. Resident #60 was 3/4/2021 with diagnointervertebral disc do region. Resident #60's quar (MDS) dated 9/15/20	cionist was in the bathroom at ad to gain access. The form ober received verbal and was signed by the form did not include any be that the family member rievance resolution. 129/21 at 4:32 PM, the SW acility grievance officer. She department supervisor listed appleted the grievance ner to resolve any concerns. Always communicated avidual who initiated the diff they wanted a copy of the ed she was not aware until an grievance response was 130/21 at 1:47 PM, the ON stated it was their an grievance resolution be a that initiated the grievance. 14 admitted to the facility on	F 585	Administrator, DON, or designee to monitor and ensure that all grievance have a written notification of the grieval resolution sent to the appropriate part The resident, RP, and or family mem This monitoring process will take plaweekly for 4 weeks then monthly for months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan. The QAPI Committee camodify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/26/2021	vance rty. aber. ce 4 cess ee for ation an

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345509	B. WING _			C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDI	EEN		STREET ADDRESS, CITY, STATE, 2 915 PEE DEE ROAD ABERDEEN, NC 28315	ZIP CODE	03/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED		DATE
F 585	daily living. The facility's grievance filed two grievances. filed a grievance regarduarantine being 14 of 9/15/2021 Resident for regarding Nurse Aide of bed in the morning his preference for his colostomy and not the Congression of the Con	ce log revealed Resident #60 On 3/15/2021 Resident #60 arding the length of his days instead of 7 days. On #60 filed a grievance es (NAs) not getting him out g at his preferred time and a nurses to manage his e NAs. B PM an interview was dent #60. He stated he did worker and the Director of ding his grievances but he red a written copy of evances. Inducted with the facility's 28/2021 at 11:08 AM. She d most of the grievances. E DON and the Administrator evances as well. The social d the department heads vances and all grievances e stand-up meeting held social worker stated she residents regarding w up was verbal. The social as not aware the regulation reponse summary. Inducted with the Director of the Administrator on I'M. Both stated they expect	F5	585		
	,	M. Both stated they expect a written resolution				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345509	B. WING _		09/3	; 80/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		, 3333333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 604 SS=E	CFR(s): 483.10(e)(1) §483.10(e) Respect The resident has a r and dignity, including §483.10(e)(1) The ri physical or chemical purposes of disciplin required to treat the consistent with §483 §483.12 The resident has the neglect, misappropri and exploitation as of includes but is not lir corporal punishment any physical or cher treat the resident's n §483.12(a) The facil §483.12(a) The facil §483.12(a) The facil includes of disciplin from physical or cher purposes of disciplin from physical or cher fro	and Dignity. ight to be treated with respect g: ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms, 12(a)(2). right to be free from abuse, ation of resident property, lefined in this subpart. This mited to freedom from initial restraint not required to medical symptoms. ity must- e that the resident is free mical restraints imposed for e or convenience and that reat the resident's medical	F	F-604 This plan of correction constitutes written allegation of compliance. Preparation and submission of this	a	10/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			09/3	30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	L	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE				
				915 PEE DEE ROAD				
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 604	Continued From page	e 15	F 6	04				
F 604	assessments. The fact the use of a resident wall as a physical res (Resident #32 and Rereviewed for physical included: 1. Resident #32 was diagnosis of a Cerebra Review of Resident # included the intervent around his feeding turn into the stomach for resident. This intervent 10/16/19. Review of Resident # Physician orders included for an abdominal bind depression disorder,	complete quarterly restraint cility also failed to identify bed pushed up against a traint. This was for 2 esident #59) 2 residents restraints. The findings admitted on 12/21/18 with a ral Vascular Accident. 32's feeding tube care plantion of an abdominal binder be (a tube inserted directly nutrition) as tolerated by the intion was last revised on 32' September 2021 added an order dated 1/6/20 der related to major poor safety awareness and	F 6	correction does not constitute a admission or agreement by the the truth of the facts or alleged, correctness of the conclusions on the statement of deficiencies of correction is prepared and so solely because of the requirem state and federal law and to de the good faith attempts by the primprove the quality of life of each Root Cause: The Administrator and the Direct Nursing discussed with the IDT committee team on 9/30/2021 the root cause of this alleged non-compliance. Root cause all conducted revealed that the all non-compliance resulted from itaning/understanding of the noregarding the recognition of an	e provide, or the set forth s. This pubmitted ent under monstrar provider ch resident to identify nalysis eged inadequating st abdomir	lan ler te to ent.		
		t his feeding tube. Release s of daily living (ADL) care needed every shift.		binder as a restraint as well as pushed up against the wall. For affected resident(s):	a bed			
	record (EMR) include Review for Reduction indicated an abdomin determination section as follows: Are the cu device(s) or bed place considered a restrain choice of "yes" was c indicated Resident #3	ement for the resident t? The form indicated the hecked. The assessment 32 was not a candidate for a elimination due to a history		Resident #59's bed was remove against the wall by the Administ the Regional Director of Operation 9/29/2021. A trial as conducted 10/20/21 to use least restrictive secure medically needed feeding resident #32. MD changed order abdominal binder to secure loc 10/20/2021 to secure feeding to Resident #32 will be assessed and as needed for any change by the clinical team.	trator an tions on d on e device ng tube f er from k on ube. quarterly	to for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI				С	
		345509	B. WING			1	/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	30/2021	
					15 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		Α	BERDEEN, NC 28315			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 604	Continued From page	e 16	F	604				
	Review of Resident #	32's quarterly Minimum						
		d 8/4/21 indicated severe			For other residents with the potential to	be		
	cognitive impairment				affected:			
	behaviors. He was co	oded for total assistance with						
	all his ADLs and code	ed as having no restraints.			An audit was completed by the Directo	r of		
					Nursing on 9/30/2021 and no other			
		nistration observation on			abdominal binders were in use nor wer			
		Nurse #1 removed Resident			there any other beds noted against the			
		d his gown. Observed			wall. The systemic changes stated belo			
		s abdomen was an off-			have been put in place to prevent any	isk		
	white stretchy abdom				of affecting additional residents.			
		s torso and was secured he feeding tube insertion			Facility plan to prevent re-occurrence:			
		t loosen the abdominal			Facility plan to prevent re-occurrence.			
		ident #32's feeding tube but			To protect residents from similar			
		er up to access his feeding			occurrences, on 10/13/2021 the Direct	or		
		Resident #32 had to wear			of Nursing, Staff Development			
	the abdominal binder	due to a history of pulling			Coordinator, and Unit Manager initiated	t		
	out his feeding tube.	• • •			re-education to the nursing staff regard	ing		
					what is considered a restraint, the prop	er		
		8/21 at 3:25 PM, Nursing			process for restraint use that includes t			
	Assistant (NA) #4 sta				need for a restraint reassessment, and			
	_	any effort to remove or			reduction attempt along with supporting			
		ninal binder. She stated as			documentation. All nursing staff education			
	far as she was aware	-			will be completed by 10/25/2021 and w	111		
		s released was during ADL			not return to work without this re-education.			
	feeding tube care.	n the nurse performed his			re-education.			
	leeding tube care.				To protect residents from similar			
	In an interview on 9/2	9/21 at 10:07 AM, the			occurrences, on 9/30/2021 the Regiona	al		
		OON) stated the abdominal			Clinical Reimbursement Consultant			
		dered a restraint but rather			provided re-education to the Minimum			
	served as protection	of Resident #32's surgical			Data Set (MDS) coordinator regarding	the		
	site. She clarified the	surgical site was the			need for accurate coding on the MDS t			
		eding tube. The DON stated			reflect the use of an abdominal binder	as		
		needed, the facility had to			a restraint.			
		assessment, obtain consent						
		ne responsible party and			Facility plan to monitor its performance			
	⊢obtain Physician orde	ers. She stated any restraint			make sure that solutions are sustained	•	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EN		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 SC 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 604	In an interview on 9/2 stated Resident #32' restraint, medically ne considered an article In an observation on #1 asked Resident #35 binder. There was no Nurse #1 made multip Resident #32 unfaste Resident #32 never nunderstand of what Nurse #1 stated he had Resident #32 attempt binder but there had I would be loose. He simaybe a staff member the binder. In an interview on 9/3 stated Resident #32 vermove his abdominations observed him making. In an interview on 9/3 Administrator and DC	at least quarterly to medical necessity or if a bould be attempted. 9/21 at 10:32 AM, the MD abdominal binder was not a ecessary and was of clothing. 9/30/21 at 9:30 AM, Nurse 82 to unfasten his abdominal response from the resident. Dole attempts to have in his abdominal binder. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The response from the resident was asking of him. The resident	F 60	A monitor sheet will be done by Administrator, DON, or designed monitor and ensure that all resic free from unnecessary restraints accuracy of MDS coding of restralong with supporting document that a restraint reassessment ar reduction has been attempted a quarterly for any resident that he restraint. This monitoring procest place weekly for 4 weeks then in 4 months. Any issues during monitoring with addressed immediately. The Administrator, DON, or designed report findings of the monitoring to the facility Quality Assurance Performance Improvement Commany additional monitoring or monof this plan. The QAPI Committed modify this plan to ensure the faremains in substantial compliance of 10/26/2021	e to dents are s, raints sation, and nd t least as a ss will take nonthly for Il be e will process and mittee for diffication ee can acility ce.		

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 9/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDI			STREET ADDRESS, CITY, STATE, ZIP COD 915 PEE DEE ROAD ABERDEEN, NC 28315	•	09/30/2021	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 604	June 2021 (6/10/21 a was found on the floor Review of Resident # Set (MDS) dated 9/1 cognitive impairment verbal and physical be extensive to total assignation daily living (ADLs). Review of Resident # included an intervent Resident will have a her bed with the left family request. In an observation on Resident #59 was obwas pushed up again. In an interview on 9/2 Development Coordi Resident #59's family pushed up against the because that was the bed in the past. The would not be able to	#59's two fall incidents in and 6/21/21) indicated she or on the left side of her bed. #59's annual Minimum Data 3/21 indicated severe and she exhibited both behaviors. She was coded for sistance with her activities of resident #59 was coded as #59's fall care plan last ion dated 8/18/21 that read: fall mat to the right side of side of the bed to the wall per 9/27/21 at 9:55 AM, eserved lying in her bed that ast the wall on her left side.	F 6				
	Assistant (NA) #4 sta and the bed had bee	28/21 at 3:25 PM, Nursing ated she came in one day n moved up against the wall. She it was to prevent Resident					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMF	E SURVEY PLETED	
		345509	B. WING			C / 30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		1 00/00/2021	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 604	Director of Nursing (Ino restraint assessmobtained because it of The DON stated Reswall was a restraint. restraint was needed a restraint assessmore resident or the responsible for the reassessed at least medical necessity or In an interview on 9/3 #1 stated the staff medical on that side to kall left side of her bed. It was possible for Resbed on the right side. In an interview on 9/3 stated the Resident in the staff medical responsible for Resbed on the right side.	29/21 at 10:07 AM, the DON) stated there had been ent and no consent was was the request of the family. Sident #59's bed against a The DON stated when a I, the facility had to complete ent, obtain consent from the nsible party and obtain e stated any restraint had to st quarterly to determine an attempt in a reduction. 29/21 at 2:34 PM, Physician oved her bed up against the eep her from falling out of the le stated he did not think it ident #59 to get out of the unless assisted by the staff.	F 6	04			
F 623 SS=B	Administrator and D0 #59's bed was move would be considered Notice Requirements	s Before Transfer/Discharge -(6)(8) before transfer. sfers or discharges a nust-	F 6.	23		10/26/21	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,			(X3) DATE SURVEY COMPLETED		
		345509	B. WING _			C 09/30/2021		
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		3373372021		
(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 623	representative(s) of the reasons for the residence of the Long-Term Care Orn (ii) Record the reasons discharge in the residence with parand (iii) Include in the notoparagraph (c)(5) of the Section of the section; (b) The safety of individual be endangered under this section; (c) The resident is transferred under paragraph (c) (c) The resident of the endangered under paragraph (c) (d) An immediate transfer of the section; (e) An immediate transfer of the section; (f) The resident of the endangered under paragraph (c) (f) An immediate transfer of the section; (g) An immediate transfer of the section of the secti	the transfer or discharge and move in writing and in a ser they understand. The copy of the notice to a coffice of the State abudsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section; tice the items described in his section. In of the notice. In of the notice. In of the notice of transfer or under this section must be at least 30 days before the ad or discharged.	F 6	23				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		09/30/2021	
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 623	(iii) The location to witransferred or dischard (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omle (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and developmental disabilities, the mailing telephone number of the protection and developmental disabilities, the mailing telephone number	nsfer or discharge; of transfer or discharge; hich the resident is rged; re resident's appeal rights, address (mailing and email), er of the entity which hits; and information on how form and assistance in and submitting the appeal residents with intellectual residents with resident residents with resident residents with a mental resident	F 62	3		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 09/30/2021
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 623	Continued From pag	e 22	F 62	23	
	In the case of facility the administrator of the administrator of the written notification provided to the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residence as a state of the residence of the residenc	onsible party (RP) written son for a hospital transfer for wed for hospitalization and #54). d: originally admitted to the rith diagnoses that included Bodies, seizure disorder and cal record revealed the addischarges: the hospital on 5/10/21 and the facility on 5/14/21. the hospital 7/19/21 and the facility on 7/23/21. the hospital on 8/19/21 and		F-623 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pla correction does not constitute an admission or agreement by the provid the truth of the facts or alleged, or the correctness of the conclusions set fort on the statement of deficiencies. This of correction is prepared and submitte solely because of the requirement und state and federal law and to demonstre the good faith attempts by the provide improve the quality of life of each resident Root Cause: The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequatraining/understanding of the Social	er of h plan d der ate r to dent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		00	C 9/30/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		70072021	
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	0 1 15	00					
F 623	Continued From page		F 62				
	The quarterly Minimu			Service Director regarding prop			
		17/21 indicated Resident		notification requirements for the			
	#62 had moderately i	mpaired cognition.		a hospital transfer provided to t	ne resident		
	Б	D (#00! DD		and/or responsible party.			
		vith Resident #62's RP, she		F#			
		t received anything in writing		For affected resident(s):			
	the early part of 2021	62's hospital transfers since		Resident #62 and #54 have ret	urned to		
	the early part of 2021	•		the facility and resident #64 nov			
	On 9/29/21 at 4:31PM, an interview was			in another facility.	v resides		
		ocial Worker (SW), who		in another radiity.			
		ployment with the facility on		For other residents with the pot	ential to be		
	_	ware she was to send a		affected:			
		hospital transfer to the					
	resident and/or RP.	·		Social Worker conducted and a	udit (title:		
				F-623) of all residents that were	•		
	The Administrator wa	s interviewed on 9/30/21 at		transferred and discharged in the	ne last 30		
	12:39 PM and stated	he was not aware the		days. Audit revealed that addition			
		egarding hospital transfers		residents were affected. As a re			
	- ·	led to the resident and/or		written notification for the reaso			
		or further stated it was his		hospital transfer was provided t			
		sident and/or RP to be		resident and/or responsible par	•		
		the reason of the hospital		previously provided. Audit comp			
	transfer per the regul	ation.		10/23/2021. The systemic chan	-		
				below have been put in place to	•		
	2) Posident #64 was	originally admitted to the		any risk of affecting additional r	esidents.		
	•	originally admitted to the diagnoses that included		Facility plan to prevent re-occur	ronco:		
		ulmonary disease (COPD),		r acinty plan to prevent re-occur	Terice.		
	seizure disorder and			To protect residents from simila	r		
	23.2410 4.501401 4114			occurrences, on 9/30/2021 the	•		
	A quarterly Minimum	Data Set (MDS)		Administrator re-educated the S	Social		
		15/21 indicated she was		Service Director regarding the			
	cognitively intact.			requirement to provide the resid	dent and/or		
	• •			responsible party a written notif			
	Resident #64's medic	cal record revealed she was		the reason for a hospital transfe			
	transferred to the hos	spital on 7/31/21 and did not		·			
		· Γhere was no documentation		Facility plan to monitor its perfo	rmance to		
		transfer being provided to		make sure that solutions are su			

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 _	B. WING		C 09/30/2021		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE I	03/00/	2021	
				915 PEE DEE ROAD				
ACCORD	US HEALTH AT ABER	DEEN		ABERDEEN, NC 28315				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) OMPLETION DATE		
F 623	On 9/29/21 at 4:31 conducted with the stated she began of 5/17/21 and was unwritten reason for tresident and/or RP. The Administrator value and the written notifications were not being provalue. The Administration for the notified in writing for transfer per the regaliance and was readmitted. Resident #54 was and was readmitted. In an interview on 9 Worker stated it was the written reason to the hospital to his stated she was una 9/29/21. A telephone interview at 11:00 AM with his and unable to leave the written reason.	RP for the hospital transfer. PM, an interview was Social Worker (SW), who employment with the facility on haware she was to send a he hospital transfer to the was interviewed on 9/30/21 at ed he was not aware the regarding hospital transfers wided to the resident and/or ator further stated it was his resident and/or RP to be or the reason of the hospital gulation. As admitted on 4/23/21 with a sebral Vascular Accident. Sent to the hospital on 8/25/21 at to the facility on 8/30/21. By 29/21 at 4:32 PM, the Social as her responsibility to send out Resident #54 was transferred as Responsible Party (RP). She aware of the regulation until ew was attempted on 9/30/21 at RP. There was no answer as a message.	F 6	A monitor sheet will be done Administrator, DON, or desi monitor and ensure that all and/or responsible parties a written notification of the real hospital transfer. This monit will take place weekly for 4 monthly for 4 months. Any issues during monitorin addressed immediately. The Administrator, DON, or desi report findings of the monitor to the facility Quality Assura Performance Improvement any additional monitoring or of this plan. The QAPI Commodify this plan to ensure the remains in substantial comparts of the facility alleges compliant 10/26/2021	gnee to residents are provided a ason for a ason for a asoring proces weeks then g will be e gnee will oring process nce and Committee for modification mittee can ne facility bliance.	S		
	In an interview on 9 Worker stated it was the written reason to the hospital to his stated she was una 9/29/21. A telephone interview at 11:00 AM with his and unable to leave the analysis of the state of the stat	9/29/21 at 4:32 PM, the Social as her responsibility to send out Resident #54 was transferred s Responsible Party (RP). She aware of the regulation until ew was attempted on 9/30/21 is RP. There was no answer as a message.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		C 09/30/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/00/2021	
4000000				915 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	EN		ABERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 623	Continued From page	25	F 62	23		
		insfers to the hospital, a transfer was required.				
F 637 SS=D	•	ssment After Signifcant Chg (ii)	F 63	37	10/26/21	
	determines, or should there has been a sign resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the resider requires interdisciplinicare plan, or both.) This REQUIREMENT by: Based on record revifacility failed to complistatus Minimum Data within 14 days after the hospice program for 14 hospice (Resident #62 was origon 10/25/19 with multidementia with Lewy Eand diabetes.	mental condition. (For n, a "significant change" e or improvement in the will not normally resolve ntervention by staff or by d disease-related clinical is an impact on more than ent's health status, and ary review or revision of the is not met as evidenced ew and staff interviews, the ete a significant change in Set (MDS) assessment he resident enrolled in the l of 1 residents reviewed for 2).		F-637 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plant 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 for on the statement of deficiencies. This of correction is prepared and submitted solely because of the requirement unstate and federal law and to demonst the good faith attempts by the providing improve the quality of life of each res	der of e th plan ed der rate er to	
	8/19/21 and returned	to the facility on 8/26/21.		Root Cause:	iderit.	
	The medical record for	or Resident #62 was				

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 _			C 09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				91	15 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	:EN		Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 637	Continued From page	e 26	F	337			
F 637	reviewed and reveale 8/26/21 to admit to he diagnosis of Alzheime A review of Resident problem area initiated services. A quarterly MDS asses indicated Resident #6 cognition. Hospice was On 9/30/21 at 10:03 A interviewed and state status MDS assessm completed 14 days af hospice services and An interview was com Administrator and Dir at 12:39 PM and both	d a physician's order dated pspice services due to a per's disease. #62's care plan revealed a light on 8/30/21 for Hospice essment dated 9/17/21 for Hospice lessment dated 9/17/21 for hosp	F	337	The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identify the root cause of this alleged non-compliance. Root cause analysis conducted revealed that the alleged non-compliance resulted from inadequateraining/understanding of the Minimum Data Set Coordinator (MDS) regarding need for a significant change in status the MDS assessment within 14 days at a resident is enrolled in a hospice program. For affected resident(s): Resident #62 had a significant change done in the MDS on 10/4/2021 by the MDS Coordinator. For other residents with the potential to affected: A 100% audit (titled: F-637) of hospice residents was completed on 9/30/2021 the MDS Coordinator to ensure that all significant changes were completed. A significant had been completed. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.	ate the in fter be by II	
					Facility plan to prevent re-occurrence: To protect residents from similar occurrences, on 9/30/2021 the Regiona Clinical Reimbursement Consultant provided re-education to the Minimum Data Set Coordinator (MDS) regarding		

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	WING			C	
NAME OF D	ROVIDER OR SUPPLIER	3-3303	1 5:	ст	FREET ADDRESS, CITY, STATE, ZIP CODE	09/	/30/2021	
NAIVIE OF PI	ROVIDER OR SUPPLIER				, , ,			
ACCORDI	US HEALTH AT ABERDE	EN			5 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)		ED BY FULL PREFIX (EACH CORREC				(X5) COMPLETION DATE	
F 637	Continued From page	÷ 27	F6	337	need for a significant change in status in the MDS within 14 days after a resident enrolled in a hospice program. 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 residents newly enrolled in a hospice program has the required significant change assessment done in the MDS. This monitoring process will take place week for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee 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 10/26/2021	t is to : ave kly ss		
	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 6	641	10/20/2021		10/26/21	
	resident's status. This REQUIREMENT by:	of Assessments. t accurately reflect the is not met as evidenced ews, observations and staff			F-641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	\ , ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C	
NAME OF D	DOVIDED OD CUDDUED	343309	B. WING_	CTREET ADDRESS OITY STATE 7ID CO)/30/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
ACCORDI	US HEALTH AT ABE	RDEEN		915 PEE DEE ROAD			
				ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From p	page 28	F6	41			
F 641	interviews, the fact Data Set (MDS) a areas of falls (Resident #32), redemographics (Resident #32), redemographics (Resident #31 with the MDS Nurassessment dated #31's medical recordent #31 with the MDS Nurassessment dated #31's medical recordent #31 has readmission to the should have been falls with no injury.	sility failed to code the Minimum ssessments accurately in the sidents #31, #45, and #62), idents #63 and #59), nutrition estraints (Resident #32), and esident #58). This was for 7 of wed. ded: was originally admitted to the with diagnoses that included by Bodies, Atrial Fibrillation, and Resident #31 transferred to the 1 and was readmitted to the 1 and was coded as with no injury. Display and the 1 and 1 an	F 6	This plan of correction const written allegation of complian Preparation and submission correction does not constitut admission or agreement by the truth of the facts or alleg correctness of the conclusio on the statement of deficiency of correction is prepared and solely because of the require state and federal law and to the good faith attempts by the improve the quality of life of Root Cause: The Administrator and the D Nursing discussed with the I committee team on 9/30/202 the root cause of this alleged non-compliance. Root cause conducted revealed that the non-compliance resulted from training/understanding of the Coordinator regarding accurate MDS assessment in the medications, nutrition, restrated demographics. For affected resident(s): Resident #31, #45, #62, #63 and #58 all were corrected a accurately on the MDS by the Coordinator. All changes we	of this plan of the an the provider of ed, or the ms set forth cies. This plan disubmitted ement under demonstrate the provider to each resident. Irrector of DT QAPI 21 to identify dise analysis alleged minadequate embody are coding of areas of falls, and and coded the MDS.		
	at 12:39 PM and b	Director of Nursing on 9/30/21 both stated it was their e MDS assessment to be coded		by 10/20/2021. For other residents with the	potential to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345509	B. WING		09	C 09/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)				(X5) COMPLETION DATE	
F 641	Continued From page accurately.	e 29	F 64	affected: Auditing (titled: F-641) by the MD	5		
	12/24/12 with multiple	admitted to the facility on e diagnoses that included , dementia, and Parkinson's		Coordinator on the accuracy of coordinator on the accuracy of coordinator on the accuracy of coordinator on the MDS for all residents over the quarter to include falls, medication nutrition, restraints, and demogral Audit completed by 10/25/2021. A	oding on past ns, ohics.		
	and 8/12/21 within th look back period.	alls with no injury on 7/29/21 e 8/27/21 MDS assessment		revealed additional coding discreptions. All corrections were made as indicative as indicative to the systemic changes stated belowen put in place to prevent any raffecting additional residents.	oancies. cated. ow have		
	indicated Resident #4 cognition. She was comit with no injury and 2 coinjury. On 9/30/21 at 10:03 with the MDS Nurse wassessment dated 8/	AM, an interview occurred who reviewed the MDS 27/21 as well as Resident in MDS Nurse stated it		Facility plan to prevent re-occurre To protect residents from similar occurrences, on 9/30/2021 the Re Clinical Reimbursement Consulta provided re-education to the MDS Coordinator regarding the need for accurate coding on the MDS to re falls, medications, nutrition, restra	egional nt or flect		
	was an error that 2 facoded. An interview was con Administrator and Dir at 12:39 PM and both expectation for the Maccurately. 3) Resident #62 was facility on 10/25/19 w Parkinson's disease,	ducted with the ector of Nursing on 9/30/21 in stated it was their DS assessment to be coded originally admitted to the ith diagnoses that included dementia with Lewy Bodies He was most recently		demographics. Facility plan to monitor its perform make sure that solutions are sustant A monitor sheet will be done by the Administrator, DON, or designed monitor and ensure that all falls, medications, nutrition, restraints, ademographics are coded accurate the MDS. This monitoring process take place weekly for 4 weeks the monthly for 4 months. Any issues during monitoring will	nance to nained: ne to and hely on s will		
	readmitted to the faci	· -		addressed immediately. The			

		IDENTIFICATION NI IMBED:		ILTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			1	C / 30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315			730/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	9/11/21 with minor injinjury since his return. The quarterly Minimu assessment dated 9/#62 had moderately it coded with 2 or more. On 9/30/21 at 10:03 / with the MDS Nurse assessment dated 9/#62's medical record was an oversight not injury. An interview was con Administrator and Dirat 12:39 PM and both expectation for the Maccurately. 4) Resident #63 was 9/12/19 with diagnost dementia with behaviand depression. A review of Resident physician orders including 1 tab by mouth a Trazodone (an antide can used to aide in slat bedtime for sleep a The annual Minimum.	#62's medical record on 9/1/21 with no injury, ury and 9/16/21 with minor to the facility on 8/26/21. m Data Set (MDS) 17/21 indicated Resident mpaired cognition and was falls with minor injury. AM, an interview occurred who reviewed the MDS 17/21 as well as Resident The MDS Nurse stated it to code the fall with no ducted with the ector of Nursing on 9/30/21 in stated it was their DS assessment to be coded admitted to the facility on es that included vascular oral disturbances, insomnia #63's September 2021 uded Melatonin 10 milligrams at bedtime for insomnia and epressant medication that eep) 25mg 1 tab by mouth aid.	F	641	Administrator, DON, or designee will report findings of the monitoring proce to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modificatio of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/26/2021	for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	DEEN	9	STREET ADDRESS, CITY, STATE, ZIP CODE 115 PEE DEE ROAD ABERDEEN, NC 28315	1 33/00/2321
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 641	a hypnotic medication On 9/30/21 at 10:03 with the MDS Nurse assessment dated 9/463's medical record when she coded the looking at the use of classification of the should not have been at 12:39 PM and both expectation for the Maccurately. 5. Resident #32 was diagnosis of a Cerel feeding tube (a tube stomach for nutrition Review of Resident Physician orders incompared to the should an order for a front mechanical soft and an order for a front for nutritional support 2021 Physician order dated 9/2/21 fron nutritional support 2021 Physician order dated 1/6/20 for an a history of removing the same as a second support of the same and the	intact and received 7 days of on. AM, an interview occurred who reviewed the MDS 1/17/21 as well as Resident d. The MDS Nurse stated MDS assessment she was a Trazodone rather than drug. She stated Trazodone en coded as a hypnotic. Inducted with the irector of Nursing on 9/30/21 th stated it was their MDS assessment to be coded as admitted on 12/21/18 with a coral Vascular Accident and a sinserted directly into the only. #32's September 2021 studed an order dated 8/11/21 fit texture diet with thin liquids ozen nutritional cup three of 17/21. Resident #32's sysician orders included an or tube feeding continuously received abdominal binder related to a	F 641		
	Data Set (MDS) date cognitive impairment behaviors. He was d	ed 8/4/21 indicated severe t and he exhibited no coded for total assistance with aily living. Review of section K			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	PROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 03/30/2021
(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 APPROFIDEFICIENCY)	D BE COMPLETION
F 641	(Swallowing/Nutrition not coded for the nute feeding tube and not by mouth. Review of indicated he was not abdominal binder at Resident #32 from 10 During an medication 9/28/21 at 10:20 took all medications did get a frozen nut three times a day with feedings. Observed abdomen was an of binder that went conwast secured with Vitube insertion site. In an interview on 9 Nurse stated she disection P accurately coded Resident #32 intake but stated she binder was conside. In an interview on 9 Administrator and E was their expectation accurately. 6. Resident #59 was cumulative diagnos insomnia, bilateral kildementia with behall Review of Resident Physician orders incomplete in the second state of the	onal Status) indicated he was utritional approach of his of coded for any nutrition taken of section P (restraints) of coded for the use of an as a restraint to prevent removing his feeding tube. On observation with Nurse #1 AM, he stated Resident #32 Is through his feeding tube but ritional supplement by mouth while on continuous tube around Resident #32's fff- white stretchy abdominal mpletely around his torso and felcro covering the feeding with the stated she should have a for his tube feedings and oral fed in think the abdominal red a restraint. In AM, he stated she should have a feeding with the stretchy abdominal mpletely around his torso and felcro covering the feeding with the stated she should have a for his tube feedings and oral fed in think the abdominal red a restraint. In AM, the MDS do not code a restraint. In AM, the MDS do not code a restraint. In AM, the MDS do not code a restraint. In AM, the MDS do not code a restraint.	F 64	11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN	•	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	·	0.00.2021	
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	Continued From pag	e 33	F 6	641			
	Set (MDS) dated 9/1 taking any antidepre hypnotic.	#59's annual Minimum Data 3/21 indicated she was not ssants but was taking an					
	Nurse stated she coowas prescribed for ra	30/21 at 10:15 AM, the MDS ded the Trazadone for what it ather than the medication ated it was inaccurate and an					
	In an interview on 9/30/21 at 1:47 PM, the Administrator and Director of Nursing stated it was their expectation that the MDS be coded accurately.						
	3/4/2021 with diagno	admitted to the facility on oses that included vascular accident (stroke)					
	(MDS) dated 9/2/202 cognitively intact, un	derstood by others and able erstood. She was coded as					
	dated 6/15/2021 reveas female. An interview was cor 09/28/21 at 12:25 PM	#32's previous quarterly MDS ealed the resident was coded nducted with Resident #32 on M. She stated she was digender at birth was female.					
	conducted with Nurs	Opm an interview was e # 3. She stated she care for Resident #32 and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25.			(c	
		345509	B. WING _			09/	30/2021	
NAME OF PROVID	DER OR SUPPLIER	EN		915 F	EET ADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD RDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
resi fem 09/2 with was hav On con faci the F 656 Dev CFF §48 §48 imp carr resi §48 obje med ass des (i) T or n phy requ (ii) / und prodund trea (iii) reha	anale. 29/21 at 3:09 PM at the MDS nurse. So an error on her prove been coded as for a sill of the model of	an interview was conducted She stated the demographic art. Resident #32 should female. 9pm and interview was rector of Nursing and the Both stated they expected correctly. comprehensive Care Plans sillity must develop and densive person-centered sident, consistent with the sthat §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ded in the comprehensive care plan must person to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 1.10(c)(6). Bervices or specialized the nursing facility will		641			10/26/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	DATE		
F 656	findings of the PASAI rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was asselocal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set fortisection. This REQUIREMENT by: Based on observation record review, the fact comprehensive care contractures and phy 2 (Resident #24 and residents reviewed for The findings included 1. Resident #24 was diagnosis of a Cerebia Resident #24's quarte (MDS) dated 7/29/21 impairment and he exwas coded for total a of daily living and coobilateral upper extrements with the resident and the exwas coded for total a of daily living and coobilateral upper extrements.	a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and eference and potential for illities must document is desire to return to the essed and any referrals to es and/or other appropriate esse. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced estagrant in the areas of escal restraints. This was for Resident #32) of 17 or comprehensive care plans. It is admitted on 2/4/20 with a real Vascular Accident. The plan in the areas of estagrant in the areas of estagr	F 6	F-656 This plan of correction constitute allegation of complian Preparation and submission correction does not constitute admission or agreement by the truth of the facts or allege correctness of the conclusion on the statement of deficience of correction is prepared and solely because of the require state and federal law and to the good faith attempts by the improve the quality of life of expectations. The Administrator and the Direction of	nce. of this plan e an he provider ed, or the he set forth hies. This pla submitted hent under demonstrate e provider to each reside	of an r e	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
			7 ti Boilebii			С	
		345509	B. WING _		09	9/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STATE, ZIP CODE		7,00,2021	
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABE	RDEEN		ABERDEEN, NC 28315			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PRÉFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)		COMPLETION DATE	
F 656	Continued From p	age 36	F 6	56			
	contractures.	3		committee team on 9/30/2021	to identify		
	Contractar co.			the root cause of this alleged	to identity		
	In an interview on	9/30/21 at 10:15 AM, the MDS		non-compliance. Root cause a	analysis		
	nurse stated she of	completed record review,		conducted revealed that the a	lleged		
		d completed observations with		non-compliance resulted from	•		
		orehensive care plan. She		training/understanding of the N			
		24's bilateral hand contractures		Coordinator regarding the con	•		
		care planned. She stated it was		comprehensive care plan in th			
	an oversight.			contractures and physical rest	rainis.		
	In an interview on	9/30/21 at 1:47 PM, the		For affected resident(s):			
	Administrator and	Director of Nursing (DON)					
		ed Resident #24's hand		Resident #24's care plan was			
	contractures would	d have been care planned.		reflect limited range of motion			
				resident #32's care plan was u	•		
		as admitted on 12/21/18 with a		reflect change from abdomina			
	diagnosis of a Cer	ebral Vascular Accident.		secure lock device. All update completed by the MDS Coordi			
	Review of Resider	nt #32's quarterly Minimum		10/20/2021.	nator as or		
		ated 8/4/21 indicated severe		10/20/2021.			
	, , ,	ent and he exhibited no		For other residents with the po	otential to be		
		s coded for total assistance with		affected:			
	all his activities of	daily living (ADLs) and coded					
	as having no restr	aints.		An audit (titled: F-656) was co	mpleted by		
				DON for all residents 10/21/21			
		nt #32' September 2021		residents were identified using			
		ncluded an order dated 1/6/20		binder. No other residents wer			
		oinder (a wide compression belt abdomen) related to major		to have new contractures or w limitations in Range of Motion	•		
		er, poor safety awareness and		systemic changes stated below			
	1 -	out his feeding tube. Release		put in place to prevent any risl			
		vities of daily living (ADL) care		additional residents.			
		as needed every shift.					
				Facility plan to prevent re-occi	urrence:		
		nt #32's care plan last revised					
		ude a care plan for an		To protect residents from simil			
	abdominal binder	as a physical restraint.		occurrences, on 9/30/2021 the	•		
	 	0/20/24 -t 0:20 ABA Norman		Clinical Reimbursement Cons			
	ın an opservation	on 9/30/21 at 9:30 AM, Nurse		provided re-education to the M	פטוי	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	((X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 09/30/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00,00,2021	_
4.000DDU	IO LIEALTIL AT A DEDDE	EN		915 PEE DEE ROAD			
ACCORDI	JS HEALTH AT ABERDE	EN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	N
F 656	Continued From page		F 6		_		
		32 to unfasten his abdominal		Coordinator regarding the need			
	Nurse #1 made multip	response from the resident.		completion of the comprehensive plan in the areas of contractures			
	Resident #32 unfaste	ned his abdominal binder. noved nor acknowledged		restraints.	s anu		
		urse #1 was asking of him.		Facility plan to monitor its perform	rmance t	o	
		ad not personally ever seen		make sure that solutions are su	stained:		
	•	to remove his abdominal					
		peen instances where it ated he could not say that		A monitor sheet will be done by Administrator, DON, or designe			
		r did not adequately secure		monitor and ensure that resider			
	the binder.	and not adoquatory occurs		contractures and restraints are		y	
				reflected in a comprehensive ca			
		0/21 at 10:15 AM, the MDS		This monitoring process will take			
	nurse stated she com			weekly for 4 weeks then monthl	y for 4		
		ompleted observations with		months.			
	stated she did not cor	nensive care plan. She		Any issues during monitoring wi	ill he		
	abdominal binder as a			addressed immediately. The			
	In an interview on 9/3	0/21 at 1:47 PM the		Administrator, DON, or designer report findings of the monitoring			
		N stated they expected the		to the facility Quality Assurance			
		omplete and comprehensive		Performance Improvement Com		or	
	care plan.	·		any additional monitoring or mo			
				of this plan. The QAPI Committee			
				modify this plan to ensure the fa remains in substantial complian			
				The facility alleges compliance	on		
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)(F 6			10/26/21	
	() ()(-)(, , ,					
	§483.21(b) Comprehe						
	- , , , ,	orehensive care plan must					
	be-						
	(i) Developed within 7 the comprehensive as	days after completion of					
	the complehensive as	55C55IIICIII.					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345509	B. WING			1	30/2021
ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2021
US HEALTH AT ABERDE	EEN					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
(ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practive the resident and their An explanation must medical record if the and their resident repnot practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by th (iii)Reviewed and reviteam after each asse comprehensive and cassessments. This REQUIREMENT by: Based on record revifacility failed to review the area of falls (Resithe area of isolation price and review the area of solation price and review the area of solatio	terdisciplinary team, that nited to ysician. with responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident participation of the resident's needs to resentative is determined to development of the resident's needs to resident. The participation of the resident in the resident	F	657	F-657 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the 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	er of I Iolan	
unsteadiness on feet				state and federal law and to demonstra the good faith attempts by the provider	te to	
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR I Continued From page (ii) Prepared by an in includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and their resident reprotent practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii)Reviewed and reviteam after each assecomprehensive and cassessments. This REQUIREMENT by: Based on record revited facility failed to review the area of falls (Resithe area of isolation processes the second falls (Resithe area of solation processes the second falls (Re	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	A BUILDI ROVIDER OR SUPPLIER US HEALTH AT ABERDEEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise care plans in the area of isolation precautions (Resident #62). This was for 2 of 17 resident care plans reviewed. The findings included: 1) Resident #31 was originally admitted to the facility on 2/3/20 and most recently readmitted on 7/28/21. His diagnoses included dementia with Lewy Bodies, atrial fibrillation, history of falls and unsteadiness on feet.	A BUILDING B	NOVIDER OR SUPPLIER 345509 345509 STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315 SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST ES PERCEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident and the resident's representative (s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident, (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise care plans in the area of folacition precautions (Resident #62). This was for 2 of 17 resident care plans reviewed. The findings included: 1) Resident #31 was originally admitted to the facility on 2/3/20 and most recently readmitted on 7/28/21. His diagnoses included dementia with Lewy Bodies, atrial fibrillation, history of falls and unsteadiness on feet.	A BUILDING 345509 345509 345509 345509 345509 35TREET ADDRESS, CITY, STATE, ZIP CODE 999 915 DE DE ROAD ABERDEEN NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 38 (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (C) A nurse alde with responsibility for the resident. (C) A nurse alde with responsibility for the resident. (C) A nurse and the resident st representative is determined not practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident and and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This RECUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility falled to review and revise of the text of the resident facility falled to review and revise care plans in the area of Isolation precautions (Resident #62). This was for 2 of 17 resident care plans reviewed. The findings included: 1) Resident #31 was originally admitted to the facility on 2/3/20 and most recently readmitted on 7/28/21. His diagnoses included dementia with Lewy Bodies, attial fibrillation, history of falls and unsteadiness on feet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 09/30/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		J9/30/2021	
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315			
	OUR MARRY OF	TITLIFIE OF DEFINITION		·	ODDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From page	e 39	F 65	57			
	assessment dated 8/ had severe cognitive wheelchair was used	•		Root Cause:			
	Resident #31's care ¡	plan revealed a focus area tions that included a referral		The Administrator and the Di Nursing discussed with the I committee team on 9/30/202	DT QAPI		
	for a high back whee	lchair for positioning. This		the root cause of this alleged	. t		
		ated on 4/23/21 and the care		non-compliance. Root cause			
	plan was most recent	tly reviewed on 8/5/21.		conducted revealed that the			
				non-compliance resulted from			
	_	nade of Resident #31 on and 9/29/21 at 11:38 AM and		training/understanding of the			
	he was sitting up in a			Coordinator regarding care part and revision in the areas of f			
	The was sitting up in a	regular wheelchair.		isolation precautions.	alis aliu		
	An interview occurred	d with Nurse #2 and Nurse		isolation procautions.			
		/21 at 11:38 AM. Both used a regular wheelchair		For affected resident(s):			
	for mobility and was i	unable to recall if he had		Resident #31s care plan was	s revised for		
	ever used a high bac	k wheelchair.		falls and resident #62s care revised for isolation precaution			
	the Rehab Director w			MDS Coordinator on 9/30/20			
	high back wheelchair	onfirmed he was not using a and was unaware if this had n intervention for falls.		For other residents with the paffected:	potential to be		
				A care plan review and revis			
		interviewed on 9/30/21 at		(titled: f-657) was completed	-		
		ewed Resident #31's medical		Coordinator for residents that			
		e intervention for a high back ave been resolved when the		and that have been under iso			
		red, by her, on 8/5/21 as		precautions for the last quart completed by 10/25/2021. N			
	Resident #31 did not			inaccuracies were noted. Th			
	1 135 Idon't #01 did Hot	acc and for modificy.		changes stated below have l			
	An interview occurred	d with the Administrator and		place to prevent any risk of a	•		
		n 9/30/21 at 12:39 PM. Both		additional residents.	J		
		expectation for the care plan					
		resentation of the resident,		Facility plan to prevent re-oc	currence:		
	, ,			To protect residents from sin	nilar		

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_		00	C 9/30/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		730/2021	
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABEF	RDEEN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From p		F 6		D		
	facility on 10/25/19 on 8/26/21. His dia disease, history of Bodies and unstead A review of Reside physician orders ir - An order dated 8 - An order dated 9 lowest position por - An order dated 9 sides of the bed, whowest position for Hospice to provide (DME). A quarterly Minimulassessment dated #62 had moderate wheelchair for molyminor injury. Resident #62's call 9/20/21, revealed interventions that in - New bed/crank bed. This was initiated. This was on 9/28/21. Remove fall mats up and stand without the second process. The second process in the second process in the second process in the second process. The second process is the second process of the bed provided in the second process of the bed provided process. The second process is the second process of the bed provided provided provided process of the bed provided provided process of the bed provided provided provided provided process of the bed provided prov	ent #62's September 2021 ncluded the following: /26/21 for Hospice services. /2/21 for the bed to be in the ssible when resident is in bed. /13/21 for fall mats to both vinged mattress, and low bed in safety promotion interventions. e durable medical equipment Im Data Set (MDS) 9/17/21 indicated Resident ly impaired cognition, use of a boility and 2 or more falls with re plan, last reviewed on a focus area for falls with included: ed in place. Remove electrical		occurrences, on 9/30/2021 the Clinical Reimbursement Comprovided re-education to the Coordinator regarding the neand revision of care plans in falls and isolation precautions. Facility plan to monitor its permake sure that solutions are A monitor sheet will be done Administrator, DON, or designonitor and ensure that resignant are reviewed and revision necessary in the areas of fall isolation precautions. This maprocess will take place week then monthly for 4 months. Any issues during monitoring addressed immediately. The Administrator, DON, or design report findings of the monitor to the facility Quality Assurant Performance Improvement Cany additional monitoring or of this plan. The QAPI Commodify this plan to ensure the remains in substantial compliance.	sultant MDS ed for review the area of s. rformance to sustained: by the nee to dents care ed as s and onitoring ly for 4 weeks will be nee will ing process ce and committee for modification nittee can e facility fance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345509	B. WING		09/30/2021		
	ROVIDER OR SUPPLIER	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 00/00/2021		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
F 657	of Resident #62 whi bed was in the lower mattress was present either side of the between positioned against the side of the between the side of the between positioned against the side of	AM, an observation occurred le he was in bed. The electric st position possible, winged nt, fall mats were present to d and the bed was not	F 65	,			
	An interview occurred Director of Nursing of both indicated it was plan to be an accurate.	re occurred when she lan on 9/20/21. red with the Administrator and on 9/30/21 at 12:39 PM. They is their expectation for the care ate representation of the ted by the MDS Nurse.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		X3) DATE SURVEY COMPLETED
		345509	B. WING			C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDI	EEN		STREET ADDRESS, CITY, STATE, ZIP COD 915 PEE DEE ROAD ABERDEEN, NC 28315)E	33/33/2021
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATI	(X5) COMPLETION DATE
F 657	Continued From pag	e 42	F 6	57		
	facility on 10/25/19 a on 8/26/21. His diagr	originally admitted to the nd most recently readmitted noses included Parkinson's lling, dementia with Lewy ness on feet.				
	#62 had moderately	17/21 indicated Resident impaired cognition and e for active infectious				
	for isolation precaution had COVID vaccination	plan revealed a focus area ons due to resident has not ons. This focus area was d the care plan was most 9/20/21.				
	of Resident #62 while no indication Resider	AM, an observation occurred to the was in bed. There was in the was in the was under isolation ommate was present in the				
	at 10:30 AM, who ve under quarantine pre	d with Nurse #2 on 9/28/21 rified Resident #62 was cautions shortly after his tal on 8/26/21 but was no recautions.				
	10:03 AM. She revie record and stated the	interviewed on 9/30/21 at ewed Resident #62's medical e focus care plan for isolation ave been resolved when she an on 9/20/21.				
		d with the Administrator and n 9/30/21 at 12:39 PM. They				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3	OMPLETED
		345509	B. WING			C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315			00.00.2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	plan to be an accurate resident when update	their expectation for the care e representation of the	F 6:			10/26/21
SS=D	resident, the facility m (i) A resident receives professional standard pressure ulcers and oulcers unless the individemonstrates that the (ii) A resident with professional star promote healing, prevnew ulcers from deve This REQUIREMENT by: Based on observation interviews and recordensure an air mattres healing was accurate resident's body weigh #59) of 2 residents re The findings included Resident #59 was addicumulative diagnoses contractures and a pressident #59's revise read she had a pressi	rity re ulcers. hensive assessment of a nust ensure that- s care, consistent with des of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent adards of practice, to vent infection and prevent doping. is not met as evidenced ns, staff and Physician #1 review, the facility failed to s ordered to promote wound by set based on the at. This was for 1 (Resident viewed for pressure ulcers.		F-686 This plan of correction constituted written allegation of compliance Preparation and submission of correction does not constitute admission or agreement by the the truth of the facts or alleged correctness of the conclusions on the statement of deficiencie of correction is prepared and s solely because of the requirem state and federal law and to detthe good faith attempts by the improve the quality of life of ear	e. I this plan of an I provider of an an I or the I set forth I s. This plan I ubmitted I ent under I emonstrate I provider to	f

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345509	B. WING	· · · · · · · · · · · · · · · · · · ·	(09/30/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	PΕ		
4.000 DDI	UC UEALTU AT ADEDDE	-PAI		915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EN		ABERDEEN, NC 28315			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 686	Continued From page	. 44	F 60				
F 000	Continued From page	÷ 44	F 68				
		1501 O 1 1 0001		Root Cause:			
		59's September 2021					
		uded an order dated 2/16/21		The Administrator and the Dir			
		her bed to promote wound		Nursing discussed with the IE			
	healing. There was n			committee team on 9/30/202	1 to identify		
	assessment of the air			the root cause of this alleged			
	function and/or settin	gs.		non-compliance. Root cause	-		
	Desident #E0's appur	ol Minimum Data Sat (MDS)		conducted revealed that the a			
		al Minimum Data Set (MDS)		non-compliance resulted from			
	dated 9/13/21 indicat	nsive assistance with all her		training/understanding of the nurse to ensure an air mattre			
	activities of daily livin			promote wound healing was			
	•	ounds. She was coded for		set based on the resident's b	-		
		esent on admission with a		set based on the resident's b	ody weight.		
		attress to her bed. The		For affected resident(s):			
		Area Assessment read as		r or anodisa roolaem(o).			
	-	is admitted with stage 4		Resident #59s air mattress w	as adjusted		
		acrum. Resident will receive		to the proper setting based or			
	•	pressure wound per MD		on 9/29/2021 by the Administ			
		ealing noted thru next		Regional Director of Operation			
	review."	3					
				For other residents with the p	otential to be		
	In an observation cor	npleted on 9/27/21 at 10:12		affected:			
	AM, Resident #59 wa	is lying on her left side on an					
	air mattress with the	mattress weight setting of		A 100% audit (titled: f-686) w	as completed		
	300 pounds.			on 9/30/2021 by the Director	of Nursing to		
				ensure that all air mattresses	ordered to		
		npleted on 9/28/21 at 8:50		promote wound healing were			
		is lying on her left side on an		accurately based on the resid	-		
		mattress weight setting of		All were accurately set. The s	-		
	300 pounds.			changes stated below have b			
				place to prevent any risk of a	ffecting		
		ation was conducted on		additional residents.			
		with the Treatment Nurse.					
		ved concerns related to the		Facility plan to prevent re-occ	currence:		
		atment Nurse stated when			.,		
	_	on the bed of a resident		To protect residents from sim			
		, the pressure setting were		occurrences, on 9/30/2021 th			
	aetermined by the re	sident's weight. She stated		re-educated the treatment nu	rse		

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 _				30/2021
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				91	I5 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	:EN		A	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	≥ 45	F 6	886			
F 686	the nurses set the air on the residents weig specified by the Phys In an observation and 3:15pm, the Treatmer confirmed the air mat for 300 pounds. The setting should have be pounds and not 300 p. Resident #59 did not pounds and he adjust to <250 pounds at thi Nurse stated the air in should be assessed wassessments. She stair mattress settings completed wound car oversight. In an interview on 9/2 #1 stated it was the nensure Resident #59 accurately based on 124 pounds. In an interview on 9/3 Administrator and Dir was their expectation mattress pressure set.	mattress pressure based ht or unless otherwise ician. If interview on 9/28/21 at he had not have and Nurse # 1 tress weight setting was set treatment Nurse stated the een set to less than (<) 250 bounds. Nurse #1 stated weight much over 100 ted the air mattress pressure is time. The Treatment mattress weight setting weekly during the skin atted she did not check the	F	586	regarding the process on how to accurately set an air mattress to promote wound healing based on the resident's body weight. On 10/13/2021 the Direct of Nursing, Staff Development Coordinator, and Unit Manager initiated re-education to the nursing staff regard the process on how to accurately set a air mattress to promote wound healing based on the resident's body weight. A nursing staff education will be complete by 10/25/2021 and will not return to wo without this re-education. 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 air mattress ordered to promote wound healing are accurately set based on the resident's weight. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and	or d ling n ll ed ork :	
					Performance Improvement Committee any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345509	B. WING			1	30/2021
	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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686		crease in ROM/Mobility		686 688	The facility alleges compliance on 10/26/2021		10/26/21
SS=G	resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidal. §483.25(c)(2) A reside motion receives appropriate appropriate assistance to maintain the maximum practical reduction in mobility in This REQUIREMENT by: Based on observation rehabilitation staff and and record review, the resident for the worse contractures (Resident #32). This reviewed for range of included:	cility must ensure that a the facility without limited not experience reduction in its the resident's clinical es that a reduction in range ble; and the ent with limited range of copriate treatment and range of motion and/or to ase in range of motion. The ent with limited mobility services, equipment, and the or improve mobility with the able independence unless a sedemonstrably unavoidable. The is not met as evidenced the independence and the independence with the entire is not met as evidenced the independence in the entire is not met as evidenced the independence was for motion. The findings admitted on 2/4/20 with a real Vascular Accident.			F-688 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.	er of n olan d er	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			Ι,	С	
		345509	B. WING				30/2021	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	00/2021	
					15 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		Α	BERDEEN, NC 28315			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 688	Continued From page	e 47	F	886				
		sion Screening dated 2/4/20			the good faith attempts by the provider	to		
		vidence that Resident #24			improve the quality of life of each resid			
	-	ateral hand contractures.						
					Root Cause:			
	Review of an Occupa	ational Therapy (OT)						
		of Treatment report dated			The Administrator and the Director of			
	3/4/21, under the mu	isculoskeletal System			Nursing discussed with the IDT QAPI			
	Assessment, read Re	esident #24 did not have any			committee team on 9/30/2021 to identi	fy		
	contractures present.	The evaluation read he was			the root cause of this alleged			
	, ,	ue to an increased need for			non-compliance. Root cause analysis			
	assistance, decrease	•			conducted revealed that the alleged			
		discharged from OT on			non-compliance resulted from inadequ			
	4/2/21 with no recom	mendations.			training/understanding of the nursing s			
	D : (" O	F.F. 1 (* 1.D) (on the process of assessing worsening			
		Γ Evaluation and Plan of			limitations in range of motion along with	n		
		red 4/22/21, read OT would			obtaining proper physician orders.			
		ntractures by passive range retching, joint mobilization			For affected resident(s):			
	techniques and asses				For allected residerit(s).			
	•	for the OT referral was for			Resident #24 is currently on therapy			
		ence with self-feeding and			caseload (evaluated by Occupational			
		s bilateral upper extremities.			Therapy on 10/11/2021) to address			
					bilateral hand limitations and resident #	‡ 32		
	Review of the OT Tre	atment encounter notes			had physician orders obtained on			
	from 4/22/21 to 5/12/2	21 read, manual joint			9/30/2021.			
	mobilization technique	es and stretching of						
	shortened connective	tissue and PROM was			For other residents with the potential to	be		
	provided to Resident	#24' bilateral upper			affected:			
		stiffness and increase blood						
		ot specify if the bilateral			An audit was completed on 10/21/2021	by		
	shoulders or hands w	vere addressed.			the Director of Nursing to ensure that			
	B				there were no other residents that			
		charge Summary dated			exhibited worsening limitations in range			
		M performed was to his			motion along with ensuring that all orde			
	bilateral shoulders an				are in place for current splints/orthotics			
		ctures. The goal of Resident			Audit revealed additional residents were			
	#24 was to safely we	ar the least restrictive ce during daily task without			affected. As a result, orders were receifor splints/orthotics as indicated and	veu		
	-	fort, in order to improve his			therapy referrals were made as indicate	od		

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 _			1	C / 30/2021	
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				91	5 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERD	EEN		A	BERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From pag	ye 48	F 6	888				
		in self-feeding. A scoop dish			The systemic changes stated below ha	iVe		
	with a plate guard ar				been put in place to prevent any risk of			
		is discharged with no change			affecting additional residents.			
		nd there was no documented			3			
		nat the scoop dish with a plate			Facility plan to prevent re-occurrence:			
	implemented.	•			To protect residents from similar			
					occurrences, on 10/13/2021 the DON,			
		#24's care plan, last revised			Staff Development Coordinator, and th	е		
	· ·	nclude a care plan for			Unit Manager initiated re-education to	:he		
	contractures or the r	isk for contracture			nursing staff regarding the process on			
	development.				how to identify worsening limitations in			
					range of motion along with steps to foll	ow		
		terly Minimum Data Set			if identified. This re-education also			
	, ,	1, indicated he had severe			included obtaining the proper physician			
		t and exhibited no behaviors. tal assistance with his			orders if splints/orthotics are necessary	<i>'</i> .		
		ng as well as impairment to			All nursing staff education will be completed by 10/25/2021 and will not			
	his bilateral upper ex	- ·			return to work without this re-education			
	Tilo bilateral upper ex	Archines.			return to work without this re-education	•		
	10:00 AM. There we	conducted on 9/27/21 at re no splints or protective			Facility plan to monitor its performance make sure that solutions are sustained			
		Resident #24's bilateral hand			A manitar shoot will be done by the			
	contractures.				A monitor sheet will be done by the Administrator, DON, or designee to			
	An observation was	conducted on 9/28/21 at 8:43			monitor and ensure that all residents h	ave		
		thes were noted to be			been assessed for contracture	200		
		nt #24's bilateral hands.			management and that the appropriate			
					orders have been put in place if			
	An observation was	made on 9/28/21 at 12:10			necessary. This monitoring process wil	I		
		splints or protective devices			take place weekly for 4 weeks then			
	observed in Residen	it #24's bilateral hand			monthly for 4 months.			
	contractures.							
					Any issues during monitoring will be			
		conducted on 9/28/21 at 4:00			addressed immediately. The			
		splints or protective devices			Administrator, DON, or designee will			
		it #24's bilateral hand			report findings of the monitoring proces	S		
	contractures.				to the facility Quality Assurance and			
	İ		1	- 1	Performance Improvement Committee	tor	1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/30/2021		
	ROVIDER OR SUPPLIER	DEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		1 03/00/2021		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 688	An observation was AM. There were no observed in Resider contractures. In an interview on 9/ who treated Resider referral yesterday to hands. The OT state from services on 5/1 and she only saw his skills and needs. She his bilateral hands a assessed Resident: worsening of the RC May 2021. She state referral from nursing resident's ROM but Resident #24. In an interview on 9/ Rehabilitation Direct was the nurse would give it to her and she the proper therapy of time, the therapist was creening for chang stopped. She continuthe management traturn-over, that was we stopped. She confirmed was the OT Extraction of	conducted on 9/29/21 at 8:47 splints or protective devices at #24's bilateral hand /29/21 at 12:32 PM, the OT at #24 stated she received a revaluate Resident #24's and when she discharged him 12/21, he was using his hands are denied any contractures to at that time and stated she 12/24 today and noted and in his bilateral hands since and she normally received a protect of the formal for any changes in a shad not received a referral for 12/29/21 at 12:40 PM, the for stated the normal process at fill out a referral form and the would give the referral to discipline. She stated at one were completing a quarterly the sin a resident, but it used to explain, she felt with ansition, COVID-19, and staff when the therapy screening med Resident #24 was being	F 688	any additional monitoring or modific of this plan. The QAPI Committee of modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 10/26/2021	can		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/30/2021		
	ROVIDER OR SUPPLIER US HEALTH AT ABERE	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION		
F 688	of 6 hours, as well a splint on his left fing for up to 2 hours with In an interview on 9. Assistant (NA) #5 st recently been transf and had required to in the unit and now she did not recall ard elivered from dieta assist with eating du NA #5 stated she with #24's hand contract never seen any splin until the past few dated added to his hands. In an interview on 9. stated Resident #24 assistance with his picked him up yested management. In an interview on 9. stated Resident #24 use any adaptive explicitly as a significant with the picked him up yested his bilateral hand contract the significant with the picked him up yested as any adaptive explicitly as any adaptive explicitly as any adaptive of the significant with the picked him up yested his bilateral hand contract the significant with the picked him up yested as any adaptive of the significant with the picked him up yested his bilateral hand contract the significant with the picked him up yested his bilateral hand contract the significant with the picked him up yested his bilateral hand contract the picked him up yested his bilateral hand contract the picked him up yested his bilateral hand contract the picked him up yested his bilateral hand contract the picked him up yested his bilateral hand contract the picked him up yested his bilateral hand contract the picked him up yested him the picked him the pic	o to 2 hours with a target time is would wear a resting hand ers, left hand, and left wrist in a target time of 6 hours. (30/21 at 9:00 AM, Nursing ated Resident #24 had erred from the secured unit tal assistance with his meals on the 300 hall. She stated by special plates or utensils ry because he was unable to use to his hand contractures. as uncertain when Resident tures developed but she had not sor protection in his hands by when wash clothes were for protection. (30/21 at 9:30 AM, Nurse #1 required total staff meals. He stated therapy roday for contracture (30/21 at 9:40 AM, NA #6 had to be fed and he did not puipment for his meals or for intractures. (30/21 at 9:40 AM, NA #6 had to be fed and he did not puipment for his meals or for intractures. (30/21 at 9:40 AM, NA #6 had to be fed and he did not puipment for his meals or for intractures. (30/21 at 9:40 AM, NA #6 had to be fed and he did not puipment for his meals or for intractures.	F 688	,			
	Resident #32's resti The form was signe Therapist (OT), how signatures by the nu	ng hand splint as tolerated. d by the Occupational					

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 _			09/:	30/2021		
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP 915 PEE DEE ROAD ABERDEEN, NC 28315	CODE	, , ,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE		
F 688	#32's right hand splin Attached to the commin-service education a a right-hand resting h documented resident signatures by the Uniacknowledging the nefor splinting. Review of Resident #Data Set (MDS) date cognitive impairment behaviors. He was coall his activities of daifor any impairment to extremities. Review of an Occupa Discharge Summary #32 would safely wearight fingers, right har with a target of 8 hou was discharged to stasplinting program. Review of Resident # on 9/9/21 did not include any instruput on and/or remove splint.	the need to apply Resident t. nunication form was a and training dated 8/5/21 of and splint but there was no 's name, and there were no t Manager (UM) or a nurse eed for a physician's orders 32's quarterly Minimum d 8/4/21 indicated severe and he exhibited no oded for total assistance with ly living and was not coded his bilateral upper ational Therapy (OT) dated 8/17/21 read Resident ar a resting hand splint on his and, and right wrist for up to 4 ars. The summary read he aff, who were trained in his	F	588					
		sician orders did not include							

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER	DEEN	STREET ADDRESS, CITY, STATE, ZIP COD 915 PEE DEE ROAD ABERDEEN, NC 28315		03/00/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 688	Continued From pa	ge 52	F 68	8	
		conducted on 9/27/21 at as no splint observed to hand.			
		conducted on 9/28/21 at 8:43 erved a resting hand splint on hand.			
	12:10 PM. There we	conducted on 9/28/21 at ere no resting hand splint ent #32's right hand.			
	Assistant (NA) #4 s impression that thei #32' resting hand sp was nothing in the Resident Care Guid the aides would have	/28/21 at 3:25 PM, Nursing tated she was under the rapy was applying Resident point. NA #4 stated if there electronic task area or on the le about a right-hand splint, we no way of knowing to apply, ment his right-hand splint.			
		conducted on 9/28/21 at 4:00 resting hand splint observed ight hand.			
		conducted on 9/29/21 at 8:47 sting hand splint on Resident			
	stated Resident #32 splinting schedule in notified the UM that training and was dis OT services. The O responsibility of the the physician order	/29/21 at 12:32 PM, the OT 2 was established with a n August 2021 and she she had completed the staff scharging Resident #32 from T stated it was the UM or floor nurse to obtain and enter the order into the ecord so the aides would			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/30/2021		
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 03/00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 688	Director of Nursing (to locate any physic regarding Resident and She normally stated would give the UM of communication form enter the physician of medical record so the apply the splint. She to why the process of the splint		F 68	3			
	Administrator and D	30/21 at 1:47 PM, the irector of Nursing stated it n that the facility would have					

ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 245500 B. WING	(X3) DATE SURVEY COMPLETED				
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER	EEN	STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		03/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 688	obtained and entered splinting orders into to ensure his splint a	d Resident #32's right hand the electronic medical record	F 68		10/26/21
SS=D	CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must ens §483.25(d)(1) The re as free of accident h §483.25(d)(2)Each re supervision and assi accidents. This REQUIREMEN' by: Based on record rev interview, the facility free environment by window air condition occupied by resident (Room #411). The findings included During an observation 10:46 AM and 9/28/2 conditioner (AC) unit 6-receptacle power s in use and easily accompleted are findings included A review of the facility "Power Cords and E use of "power strips Electrical Equipment only in long term car Patient Care Related	s. ure that - esident environment remains azards as is possible; and esident receives adequate stance devices to prevent T is not met as evidenced view, observations and staff failed to provide a hazard utilizing a power strip for a er unit for 1 of 14 rooms is in the memory care unit d: on of Room 411 on 9/27/21 at 21 at 11:00 AM, a window air is was plugged into a estrip, by a resident's bed, not		F-689 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this pla correction does not constitute an admission or agreement by the provid the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This of correction is prepared and submitte solely because of the requirement und state and federal law and to demonstrate and federal law and to demonstrate good faith attempts by the provide improve the quality of life of each residence. The Administrator and the Director of Nursing discussed with the IDT QAPI committee team on 9/30/2021 to identithe root cause of this alleged	an of der of th plan ed der rate er to dent.

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID IVC	7. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(C
		345509	B. WING			09/	30/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	FFN		91	15 PEE DEE ROAD		
AGGGRE	OO TILALITI AT ABERDE			Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	0 11 15		_				
F 689	Continued From page		F	689			
		for non-related items are			non-compliance. Root cause analysis		
	1 -	n, the policy stated, "the			conducted revealed that the alleged		
	electrical and mechai				non-compliance resulted from inadequ		
	assembly is regularly	verified and documented".			training/understanding of the maintena	nce	
	An interview occurred	d with the Administrator and			staff regarding providing a hazard free environment by utilizing a power strip f	or a	
	I .	on 9/29/21 at 11:00 AM.			window air conditioner occupied by	ла	
	The Administrator sta				residents in the memory care unit.		
		emory care unit was not			reducine in the memory eare unit.		
		the end of 2019 and several			For affected resident(s):		
	window AC units were	e placed at that time. They			, ,		
		felt the power strip was used			Room #411 had the power strip remov	ed	
		l was not long enough to			by the Maintenance Director on		
	1	acle. The Maintenance			9/29/2021.		
		gan employment at the					
	1 -	and was aware the window			For other residents with the potential to) be	
	· ·	s well at the power strip. He			affected:		
		tral air conditioner for the sreplaced June 2021 and			On 9/29/2021 the Maintenance Directo	\r	
		were no longer used. Both			audited (titled: f-689) all rooms to ensu		
		Maintenance Director			no other power strips were utilized for		
		t have expected the AC unit			window air conditioner. No other powe		
		lugged into a power strip,			strips were identified. the systemic		
		e been plugged directly into			changes stated below have been put in	1	
	the wall receptacle or	a receptacle should have			place to prevent any risk of affecting		
		all within the distance			additional residents.		
	needed to plug the A	C window unit in directly.					
					Facility plan to prevent re-occurrence:		
		AM an observation of Room			To marke skip orbitals () 1 1		
		ne Maintenance Director			To protect residents from similar		
		C unit was plugged into a as then plugged into the wall			occurrences, on 9/29/2021 the Administrator re-educated the		
		tenance Director stated			Maintenance Director and Maintenanc	۵	
		owed for items such as			regarding providing a hazard free	,	
		in resident rooms and should			environment and ensuring that power		
	be inspected and app				strips are not being utilized for window	air	
		was unable to provide			conditioning units.		
	I .	y regularly inspecting and			3		
		strip observed in room 411.			Facility plan to monitor its performance	to:	

		(X3) DATE COMP	SURVEY				
		345509	B. WING _				C 30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	:EN		91	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page The Maintenance Dire remove the window A		Fé	689	A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all Window air conditioning units are free from power strip usage. This monitoring process will take place weekly for 4 we then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	g eks es for	
F 755 SS=D	S483.45(a) (b) S483.45(a) (b) S483.45 Pharmacy S The facility must providrugs and biologicals them under an agree S483.70(g). The facil personnel to administ permits, but only under a licensed nurse.	ervices ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed	F7	755	10/26/2021		10/26/21

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS	TRUCTION	(X3) DATE SURVEY COMPLETED	
		345509	B. WING				C 30/2021
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
ACCORDI	US HEALTH AT ABERDE	EN			E DEE ROAD DEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 755	biologicals) to meet the §483.45(b) Service Comust employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provision the facility. §483.45(b)(2) Establicate facility. §483.45(b)(2) Establicate facility and disposition sufficient detail to enarconciliation; and §483.45(b)(3) Determorder and that an acciss maintained and perform that the facility prescribed for pain will doses for 1 of 5 (Resignature for pain will doses for 1 of 5 (Resignature for pain will doses for 1 of 5 (Resignature for pain will dose for 1 of 5 (Resign	nistering of all drugs and ne needs of each resident. onsultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of in of all controlled drugs in able an accurate nines that drug records are in ount of all controlled drugs riodically reconciled. is not met as evidenced fews, observations, staff, y failed to obtain medication hich resulted in 10 missed ident #53) reviewed for ions. : mitted to the facility on cent readmission on ting diagnoses included infection) of the vertebrae in	F	This writt Pre correct adments the correct of correct sole state imp	s plan of correction constitutes a ten allegation of compliance. Exparation and submission of this plar rection does not constitute an mission or agreement by the provide truth of the facts or alleged, or the rectness of the conclusions set forth the statement of deficiencies. This proportion is prepared and submitted ely because of the requirement under the and federal law and to demonstrate good faith attempts by the provider prove the quality of life of each resident contents.	er of I I I Er I Er I te to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
			A. BOILDII			l ,	c l
		345509	B. WING _			09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00:2021
				915	5 PEE DEE ROAD		
ACCORDI	US HEALTH AT ABERDE	EEN		AB	BERDEEN, NC 28315		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 755	Continued From page	e 58	F 7	755			
	for pain.				The Administrator and the Director of		
					Nursing discussed with the IDT QAPI		
	Resident #53's admis	ssion Minimum Data Set			committee team on 9/30/2021 to identi	fy	
	(MDS) dated 9/7/202	1 indicated she was severely			the root cause of this alleged	•	
	cognitively impaired v	with behaviors positive for			non-compliance. Root cause analysis		
	disorganized thinking	ı. Resident #53 required			conducted revealed that the alleged		
		with activities of daily living			non-compliance resulted from inadequa		
		ppioid 6 out of 7 days during			training/understanding of the nursing s		
		od. The resident was on			on the process of obtaining prescribed		
		n for pain and prn (as			controlled medication.		
		for pain. She characterized					
	10 during the assess	and rated her pain 7 out of			For affected resident(s):		
	To during the assess	ment penod.			Resident #53 had other controlled pain	,	
	The August 2021 Me	dication Administration			medication available as needed that wa		
	_	led Resident #53 had an			administered to her and with every	40	
	` ′	capsules, 75mg to be given			administration effectiveness was		
		ly for pain with a start date			documented. Pregabalin was obtained		
	for this 8/27/2021. Th	ne medication was not			and administrated on 8-31-21.		
	administered from 8/2	27/2021 through 8/30/2021.					
		d administrations during that			For other residents with the potential to	be	
		ssed administration was			affected:		
	· ·	ndicating the medication					
		administration Further			A 100% audit (titled: f-755) was comple		
	review of the August				on 10/21/2021 by the Director of Nursin	-	
	, ,	is administered orally every			to ensure all residents that are prescrib		
	four hours 8/28/2021	tillougi1 6/30/2021.			Pregabalin have an adequate supply. Nother issues were noted. The systemic		
	The August 2021 MA	R revealed Resident #53's			changes stated below have been put in		
	_	nented every shift. On			place to prevent any risk of affecting	•	
	I -	evel was documented as 4-5			additional residents.		
		10 being the worst pain					
		er pain level on 8/29/2021			Facility plan to prevent re-occurrence:		
		zero every shift, and on					
		vel was documented as low			To protect residents from similar		
	as 2 and as high as 7				occurrences, on 10/13/2021 the DON,		
		the resident were not			Staff Development Coordinator, and U	nit	
		ked to rate her pain level,			Manager initiated re-education to the		
	she did not reply.				nursing staff regarding the process on		1

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D MANAGO				C
		345509	B. WING			09/	30/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCOPDI	US HEALTH AT ABERDE	:EN		9	15 PEE DEE ROAD		
ACCONDI	OS IILALIII AI ADLINDI	-LIV		Δ	ABERDEEN, NC 28315		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 755	Continued From page	e 59	F	755			
	· -	s conducted with Nurse # 5			how to properly obtain controlled		
		PM. She stated she worked			medication prescribed for pain. All nurs	ina	
		urday 8/28/2021 and Sunday			staff education will be completed by	9	
		lays she called the pharmacy			10/25/2021 and will not return to work		
		alin. The pharmacist told her			without this re-education.		
	they had not received						
	medication and could	not fill it until the physician			Facility plan to monitor its performance	to	
	signed a hard script.	She stated she sent a text to			make sure that solutions are sustained	:	
		n on 8/28/2021 and made					
		d not recall him texting her			A monitor sheet will be done by the		
	back. She called the				Administrator, DON, or designee to		
		old the same thing. She			monitor and ensure that all residents		
		called the physician again			prescribed for controlled pain		
		e him aware the pregabalin rse #5 felt the resident's			medication(s) have an adequate supply This monitoring process will take place		
	pain was well controll				weekly for 4 weeks then monthly for 4		
	pain was well control	led during her shints.			months.		
	On 9/29/2021 at 2:37	PM an interview was					
	conducted with Nurse	e #1. He stated he provided			Any issues during monitoring will be		
	care for Resident #53	on 8/30/2021 and the			addressed immediately. The		
	pregabalin was not o	n the medication cart. He			Administrator, DON, or designee will		
	stated he personally	called the pharmacy about			report findings of the monitoring proces	ss	
	the pregabalin and th	e pharmacist stated the hard			to the facility Quality Assurance and		
		the pharmacy. The facility's			Performance Improvement Committee		
	physician would need	I to write a script and send it			any additional monitoring or modification	n	
		der could be filled by the			of this plan. The QAPI Committee can		
	pharmacy. He stated				modify this plan to ensure the facility		
		ity's physician. He did not			remains in substantial compliance.		
	recall hearing back from				The facility allowed committees on		
	' '	sident did not get the three			The facility alleges compliance on		
	stated he felt the resi	oregabalin on 8/30/2021. He			10/26/2021		
	controlled during his						
	A phone interview wa	s conducted with the					
	-	021 at 3:15pm. She stated					
		sident #53's pregabalin was					
	received in the pharm	nacy on 8/30/221 at 8:30 PM.					
	She did note the hard	script was dated 8/27/2021					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345509	B. WING_			C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	I	09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	and faxed from the fa pharmacy until 8/30/2 script was filled and the facility the morning of On 9/29/2021 at 3:26 conducted with the unphysician's orders who admitted on 8/27/202 stated she did order the pharmacy on 8/27/202 communication from pregarding a hard script was aware some medication from pregarding a hard script was aware some medicall the physician the orders in on 8/27/not call the physician the pregabalin on 8/2 Attempts to contact the pregabalin on 8/2 Attempts to contact the not successful. An interview was con Nursing (DON) and the 9/30/2021 at 12:39 Plonly been employed and the Administrator what the current procomedications that requisitated they needed to how it could be preventing of the size o	cility, but not faxed to the 021. She further stated the ne medication was in the 8/31/2021. PM an interview was not manager who entered the enthe resident was 1 around 3:30 PM. She he medication from 21. She did not receive a coharmacy on 8/27/2021 of for the medication but she dications required a hard hysician and pregabalin was ed if there was a hard script do not see it when she put 2021. She stated she did and request a hard script for 7/2021. The facility's physician were ducted with the Director of the Administrator on M. The DON stated she had with the facility for a month stated he was not certain	F 7	755		
F 756 SS=E	Drug Regimen Review	w, Report Irregular, Act On 2)(4)(5)	F 7	756		10/26/21

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345509	B. WING				30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE			9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	1 03/	50/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 756	must be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's medical facility's medical direct and these reports mu (i) Irregularities to the at facility's medical direct and these reports mu (i) Irregularities including that meets the condition of this section for (ii) Any irregularities in during this review museparate, written report attending physician and director and director and director and the irregularity the (iii) The attending phyresident's medical rectiregularity has been action has been taken be no change in the rephysician should door the resident's medical section for the resident's medical rectiregularity has been action has been taken be no change in the rephysician should door the resident's medical section for the resident's medical section has been taken be no change in the rephysician should door the resident's medical section has been taken be no change in the rephysician should door the resident's medical section has been taken be no change in the rephysician should door the resident's medical section has been taken be no change in the rephysician should door the resident's medical requires and steps when he or she identification in the requires urgent action requires urgent action the review limited to, time frame the process and steps when he or she identification in the review limited to, time frame the process and steps when he or she identification in the review limited to, time frame the process and steps when he or she identification in the review limited to, time frame the process and steps when he or she identification in the review limited to, time frame the process and steps when he or she identification in the resident in the review limited to, time frame the process and steps when he or she identification in the resident in the reside	imen Review. Ing regimen of each resident least once a month by a service with the service	F	756				

OLIVILIY	O I OIT MEDIO/ IITE &	MEDIO/ ND CEITTIGEC				OIVID IVC	7. 0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(С
		345509	B. WING			09/	30/2021
NAME OF P	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ABERDE	EEN			15 PEE DEE ROAD		
				А	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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 756	Continued From page	e 62	F	756			
		ns, staff, Physician #1 and	'	7 30	F-756		
		st interviews and record			1 -7 00		
	review, the consultan				This plan of correction constitutes a		
	· ·	arget behaviors for the use			written allegation of compliance.		
		cations. This was for 4			Preparation and submission of this plar	n of	
		ent #31, Resident #63,			correction does not constitute an		
	Resident #58) of 5 re	esidents reviewed for			admission or agreement by the provide	r of	
	unnecessary medicat	tions. The findings included:			the truth of the facts or alleged, or the		
					correctness of the conclusions set forth		
	1.Resident #59 was a				on the statement of deficiencies. This p		
	insomnia, bilateral knee contractures and solely because of the				of correction is prepared and submitted		
			solely because of the requirement under				
	dementia with behavi	oral disturbance.			state and federal law and to demonstra		
	Davious of Docidant #	EOla Cantambar 2021			the good faith attempts by the provider		
		59's September 2021 uded an order dated 8/18/21			improve the quality of life of each reside	ent.	
		otic) 1 milligram twice daily			Root Cause:		
	for yelling and screar				Noot Gause.		
	lor yelling and serear	mig.			The Administrator and the Director of		
	Review of Resident #	59's annual Minimum Data			Nursing discussed with the IDT QAPI		
	Set (MDS) dated 9/13				committee team on 9/30/2021 to identif	v	
		and she exhibited both			the root cause of this alleged	•	
		ehaviors. She was coded for			non-compliance. Root cause analysis		
	an antipsychotic take	n 7 of the 7 days during the			conducted revealed that the alleged		
	MDS look back asses	ssment. The psychotropic			non-compliance resulted from inadequa	ate	
		nt read as follows: "Resident			training/understanding of the nursing st		
		edications daily per MD			on the need for target behaviors for the	:	
	•	ent of health status and will			use of psychotropic medications.		
	receive medications a						
	complications thru ne	ext review."			For affected resident(s):		
	Resident #50's revise	ed care plan dated 8/18/21			Resident #59, #31, #63, and #58 all ha	d	
		ipsychotic medication			target behaviors added to the medication		
		screaming. Interventions			administration record by the Director of		
		and recording the occurrence			Nursing on 10/21/2021.		
	of the target behavior	_					
					For other residents with the potential to	be	
	Review of Resident #	59's September			affected:		
		inistration record (MAR) did					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING		0.0	C 9/30/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		730/2021	
				915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDI	EEN		ABERDEEN, NC 28315			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	Continued From pag	e 63	F 75	6			
		e for the nurses to document d the MAR indicated any		An audit (title: f-756) was con 10/21/2021 by the Director of ensure that all residents on p medications had target beha	of Nursing to psychotropic		
	9/22/21 read as follow MRR completed. Me	ant Pharmacist note dated ws: "Pharmacy Review Note: dical record reviewed ilable lab and progress dations at this time."		to the medication administrar Audit revealed that additional were affected. As a result, the target behaviors were added medication administration re- systemic changes stated bel	tion record. al residents ne necessary I to the cord. The		
	Review of Resident #59's nursing notes since 9/1/21 to 9/27/21 did not include any notes regarding the resident exhibiting any behaviors.			put in place to prevent any ri additional residents. Facility plan to prevent re-oc	sk of affecting		
	#59 was sleeping on In another observation at 8:50 AM, Resident being assisted with heand cooperative. Nur worked third shift so Resident #59's behaves she often yelled.	27/21 at 10:12 AM, Resident her left side in her bed. on and interview, on 9/28/21 at #59 was sitting up in bed her breakfast. She was calmose #3 stated she normally was not as familiar with viors but she was aware that		To protect residents from sim occurrences, on 10/13/2021 Staff Development Coordina Unit Manager initiated re-edunursing staff regarding the properly document tabehaviors for residents on pamedications. All nursing staff will be completed by 10/25/2 not return to work without this re-education.	nilar the DON, tor, and the ucation to the rocess on urget sychotropic f education 021 and will		
	AM, Resident #59 was observed saying unir her doll. The Treatm Assistant (NA) #3 statement wall. In an interview on 9/3 stated Resident #59 to her small stature, sharm. He stated Resident Res	ervation on 9/28/21 at 10:10 as cooperative but was atelligible speech and holding ent Nurse and Nursing ated Resident #59 was at bang her doll against the 80/21 at 9:00 AM, Nurse #1 could be combative but due she was unable to do any ident #59 often yelled out, throughout the day. At that		Facility plan to monitor its permake sure that solutions are A monitor sheet will be done Administrator, DON, or design monitor and ensure that all represcribed psychotropic meditarget behaviors to justify use monitoring process will take for 4 weeks then monthly for Any issues during monitoring	by the gnee to esidents dications have age. This place weekly 4 months.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	EEN		STREET ADDRESS, CITY, STATE, ZIP COE 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	Nurse #1 stated it was medications and he was a placed on the for behaviors. When a place to document he confirmed there wany behaviors but as what was written on the linear interview on 9/2 Director of Nursing (Edocumented behaviors stated the target behaviors were dropped in an interview on 9/2 #1 stated target behaviors were dropped in an interview on 9/2 which is the consultant Pharmacis medication review. In an interview on 9/2 consultant Pharmacis medications require the stated during his mor reviewed Physician # any behaviors. He stated the staff. In an interview on 9/3 Administrator and Documented for the staff.	egan yelling in her room. Is time for her morning was going to administer her me. Nurse #1 stated there MAR to document yes or no asked to check the MAR for behaviors related to Haldol, as no place to document sumed the behaviors were he Physician order. 19/21 at 1:17 PM, the DON) stated the nurses rs in the nursing notes. She aviors were yelling and was unsure how the bed off her MAR. 19/21 at 2:34 PM, Physician aviors should have been monthly pharmacy 19/21 at 4:43 PM, the st stated not all psychotropic behavior monitoring. He and psychiatric notes for ated if he saw monitoring by yechiatric provider, they would ained their information from 180/21 at 1:47 PM, the DN stated it was their consultant Pharmacist arget behaviors monitoring	F 75	addressed immediately. The Administrator, DON, or desig report findings of the monitori to the facility Quality Assuran Performance Improvement C any additional monitoring or r of this plan. The QAPI Commodify this plan to ensure the remains in substantial complication. The facility alleges compliant 10/26/2021	ing process ce and ommittee for modification nittee can e facility ance.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE : COMPI	ETED
		345509	B. WING _			09/3	; 30/2021
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STAT 915 PEE DEE ROAD ABERDEEN, NC 28315	TE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 756	of 7/28/21. His diagn Lewy Bodies, seizure The quarterly Minimulassessment dated 8/had severe cognitive wandering behavior days of an antipsych day assessment look Resident #31's Septe included an order for 25 milligrams (mg) by anxiety and aggressi Lewy Bodies. The day 25/28/21. Review of the Consureview notes for Resident #31's Resident motes for Resident motes from 7/28/21 to did not include docur Resident #31's Media Records (MAR's) from indicated he received exhibited no behaviors for the consurer for the company of the consurer form 7/28/21 to did not include docur form the consurer form 7/28/21 to did not include docur form form form form form for the consurer form form for the consurer form form for the consurer form for the consumption of the consurer form for the consumption of the consump	a recent readmission date oses included dementia with e disorder, and depression. Im Data Set (MDS) 1/21 indicated Resident #31 impairment. He displayed 1 to 3 days and received 7 otic medication, during the 7 to back period. Impairment and the displayed 1 to 3 days and received 7 otic medication, during the 7 to back period. Impairment and the displayed 1 to 3 days and received 7 otic medication, during the 7 to back period. In the displayed 1 to 3 days and received 7 otic medication orders are serviced and the following th	F	756	(FICIENCY)		
	observed sitting up ir common area watchi spoken to and appea	n his wheelchair in the ng TV. He smiled when ured to be in good spirits.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 00000.222
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 756	monitored for Reside observed with any be documented in the n she say if the resider On 9/29/21 at 4:43 P with the Consultant F working with the facil completed the most Resident #31 on 9/2 referred to the nursin and psychiatric programedications. He add accomplished with state behaviors were preserved medications. He add accomplished with state behaviors were preserved medications. He add accomplished with state behaviors were preserved medications. The Director of Nursing 9/30/21 at 12:39 PM expectation for the Pidentify any irregularity to include the need for use of Seroquel. 3) Resident #63 was 9/12/19 with diagnost dementia with behaviors were preserved in the programment of the Pidentify any irregularity and irregularity and irregularity includes the need for the pidentify and irregularity and irregula	anot a specific behavior and #31, however if he was chaviors they would be ursing progress notes. Did not ever had behaviors? M, an interview occurred charmacist, who started lity September 2021 and had recent medication review for 1/21. He explained he go progress notes, physician ress notes to monitor for lated to antipsychotic ded monitoring was aff documentation when ent, and he would not have behaviors to be monitored and stated it was her harmacy Consultant to the regarding Resident #31 for targeted behaviors for the sadmitted to the facility on es that included vascular ioral disturbance, insomnia, depressive disorder. Data Set (MDS) assessment ted Resident #63 was I had no behaviors. He in antipsychotic medication,	F 750		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345509	B. WING		09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERI	DEEN	9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315	,
(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 APPROPR DEFICIENCY)	BE COMPLETION
F 756	included an order for 75 milligrams (mg) in agitation related to behavioral disturband order was 5/14/21. Review of the Constreview notes for Resulting September 20 monitoring targeted. A review of Resider notes from 5/14/21 revealed behavioral 2021 and September staff members, calling of using call light, motowards staff and the requests for assistand Resident #63's Medicated he receive exhibited no behavioral targeted behaviors. On 9/28/21 at 10:12 observation of Resident and stated of his time in bed with Murse #1 was intervand stated behavior with documentation when asked what be	tember 2021 physician orders for Seroquel (an antipsychotic) by mouth at bedtime for vascular dementia with ince. The date of the original wiltant Pharmacist medication sident #63 from June 2021 21, did not reflect the need for behaviors. In the date of the original wiltant Pharmacist medication sident #63 from June 2021 21, did not reflect the need for behaviors. In the date of the original wiltant Pharmacist medication sident #63 in ursing progress to 9/28/21 was completed and its symptoms during August er 2021 of racial slurs towards in gout for assistance instead taking threatening statements are facility, and repetitive ince. Itication Administration for 5/14/21 to 9/28/21 and Seroquel as ordered and ors. The MAR did not list any for staff to monitor. In the AM, an interview and dent #63 occurred. He was in bed watching TV. He was in bed watching TV. He was in bed watching TV and resting. In the preferred to spend most atching TV and resting. In the nursing progress notes.	F 756		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		09/30/2021		
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 03/00/2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLÉTION		
F 756	Continued From pag	ge 68	F 75	56			
	with the Consultant working with the fac completed the most Resident #63 on 9/2 referred to the nursing progress notes to more related to antipsyche monitoring was according documentation when and he would not habehaviors to be more 10 mo	n behaviors were present, we recommended target sitored on a daily basis. sing was interviewed on a land stated it was her Pharmacy Consultant to sities regarding Resident #63 for targeted behaviors for the sadmitted to the facility on eccent readmission on sitting diagnoses included infection) of the vertebrae in gion, and major depressive sission Minimum Data Set 21 indicated she was severely with behaviors positive for g. Resident #53 required to with activities of daily living antipsychotic medications 7 repressants 7 out of 7 days,					
	A review of Residen	t #53's care plan, last					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C 9/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABERDI	EEN		STREET ADDRESS, CITY, STATE, ZIP COL 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	focus area: "Resident uses prelated to disease predisorder and is on an antidepressant medicincluded; administer ordered by physician effectiveness every spharmacy, physician reduction when clinic quarterly. "Resident has a stattention related to call and want nothing monitor for side effect Resident #53's Augu Medication Administrative aled an order for (mg) at bedtime for mit with a start date of 8/list target behaviors of the behaviors were pon 9/29/21 at 4:31 proconducted with NA # with Resident #53 an When asked about brelated to antipsycho not sure but she thouresident crawled out not sure where to find behaviors. On 9/29/2021 at 4:32 conducted with NA # with an agency but she thouresident crawled out not sure where to find behaviors. On 9/29/2021 at 4:32 conducted with NA # with an agency but she #53 on 9/29/2021 an her. She stated she conducted with she can be stated she conducted with she with an agency but she #53 on 9/29/2021 an her. She stated she can be stated she can be she with a stated	sychotropic medications ocess, major depressive tipsychotic and cations. Interventions psychotropic medications as . Monitor for side effects and chift and consult with , to consider dosage ally appropriate at least ochavior of yelling out for are or sometimes noted to g. Interventions included, ets and effectiveness. Set 2021 and September 2021 ation Record (MAR) Seroquel 150 milligrams major depressive disorder 27/2021. The MARs did not or any area to document if resent. In and interview was 7. She stated she did work and was familiar with her. The ehaviors being monitored tic use, she stated she was 19th it might be that the of bed sometimes. She was 15 d. Resident #53's targeted	F 75	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED		
		345509	B. WING			C / 30/2021		
	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 BY 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)	OULD BE	(X5) COMPLETION DATE		
F 756	Resident #53. On 9/29/21 at 4:33pn conducted with Nurse assigned to Resident asked about target be related to the use of 3 was new to the facilit Resident #53's target them. She further staresident talking to peroom. Progress notes from 9/29/2021 we review and revealed; "On 9/20/2021 Notesident was yelling of she needed, resident "Resident #53 was Interdisciplinary Team target behavior discutyelling out. On 9/29/2021 at 4:43 with the Consultant F working with the facil completed Resident and medication review on referred to the nursin notes, and psychiatr for specific behaviors medications. He furth accomplished with st behaviors were presented.	In an interview was a #6. She stated she was a #53 on 9/29/2021. When ehaviors being monitored Seroquel, she stated she y and she did not know to behaviors or where to find ted she has observed the ople who are not in the 8/27/2021 through end for behavioral symptoms are #4 documented the out and when asked what a stated nothing. The seed was documented as the pure an interview occurred the order of the seed was documented as the pure an interview occurred the pure and interview occurr	F 75	6				

		(X3) DATE SU COMPLE					
		345509	B. WING			C 09/30	/2021
	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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
F 756	expectation for staff to behavioral symptoms Seroquel.	g was interviewed on n and stated it was her o identify the targeted associated with the use of		756			
F 758 SS=E	CFR(s): 483.45(c)(3)(1) §483.45(e) Psychotro §483.45(c)(3) A psychological affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe	opic Drugs. hotropic drug is any drug that associated with mental rior. These drugs include, drugs in the following	F	758		10	0/26/21
	psychotropic drugs ar unless the medication specific condition as of in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral intervention contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs puruless that medication	nts who have not used re not given these drugs in is necessary to treat a diagnosed and documented ints who use psychotropic I dose reductions, and was, unless clinically in effort to discontinue these					

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 9/30/2021
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		3/00/2021
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	are limited to 14 day §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he rationale in the residindicate the duration §483.45(e)(5) PRN of drugs are limited to renewed unless the appropriateness. This REQUIREMENT by: Based on observation interviews and reconsidentify the need for those behaviors for the medications. This was Resident #31, Resident #31, Resident #31, Resident #31, Resident #59 was cumulative diagnose insomnia, bilateral kridementia with behaviors.	and orders for psychotropic drugs is. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. Orders for anti-psychotic is a days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced ons, staff and Physician #1 dreview, the facility failed to target behaviors and monitor the use of psychotropic is for 4 (Resident #59, ent #63, and Resident #53) ed for unnecessary d: admitted 9/4/20 with so f seizures, anxiety, nee contractures and	F 7	,	this plan of n provider of or the set forth this plan abmitted ent under monstrate provider to	
	Physician orders incl for Haldol (antipsych for yelling and scream	uded an order dated 8/18/21 otic) 1 milligram twice daily		Root Cause: The Administrator and the Direct Nursing discussed with the IDT committee team on 9/30/2021 to	QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
			A. BOILDII			С	
		345509	B. WING _		09	9/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	IIC HEALTH AT ADEDD	:EN		915 PEE DEE ROAD			
ACCORDI	US HEALTH AT ABERDE	EEN		ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 758	cognitive impairment verbal and physical ban antipsychotic take MDS look back perio Area Assessment reatakes psychotropic morders for improveme receive medications a complications thru nerverse medications and included monitoring a of the target behavior medication administration administration and place for behaviors nor did the behaviors. Review of Resident #9/1/21 to 9/27/21 did regarding the resident medication on 9/2 medicat	and she exhibited both behaviors. She was coded for in 7 of the 7 days during the d. The psychotropic Care and as follows: "Resident bedications daily per MD ant of health status and will as ordered with no ext review." Bed care plan dated 8/18/21 beigsychotic medication screaming. Interventions and recording the occurrence in the nurses to document any in MAR indicated any target. Begin September 2021 and a many indicated any target. Begin September 2021 and not the nurses to document any in MAR indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2021 and not the nurses to document any indicated any target. Begin September 2	F 7	the root cause of this alleged non-compliance. Root cause ar conducted revealed that the allegon-compliance resulted from it training/understanding of the number of identifying the need for target behaviors and monitor those between the use of psychotropic medical. For affected resident(s): Resident #59, #31, #63, and #5 target behaviors added to the number of administration record by the Dir Nursing on 10/21/2021 for optime monitoring. For other residents with the potal affected: An audit (titled: f-758) was comen 10/21/2021 by the Director of Nursure that all residents on psymedications had target behavior to the medication administration optimal monitoring. Audit reveal additional residents were affect result, the necessary target behavior administration record for optimal monitoring. The systemic change below have been put in place to any risk of affecting additional residents.	eged nadequate ursing staff et chaviors for tions. 88 all had nedication rector of nal ential to be pleted on ursing to chotropic ors added n record for led that ed. As a naviors al ges stated o prevent esidents. rrence:		
		was not as familiar with viors but she was aware that		To protect residents from simila occurrences, on 10/13/2021 the Staff Development Coordinator	e DON,		

CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A RULL DING			(X3) DATE SURVEY COMPLETED	
		A. BOILDIN			С	
	345509	B. WING _		09	9/30/2021	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
IS HEALTH AT ARERDE	-EN		915 PEE DEE ROAD			
OS IILALIII AI ADLINDI	-LIV		ABERDEEN, NC 28315			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
In a wound care obse AM, Resident #59 wa observed saying uninher doll. The Treatme Assistant (NA) #3 staknown to yell out and wall. In an interview on 9/3 stated Resident #59 to her small stature, sharm. He stated Resiscreamed and sang time, Resident #59 be Nurse #1 stated it was medications and he will medications at this time was a placed on the I for behaviors. When a place to document he confirmed there will an observed any behaviors but assistant was a placed on the I for behaviors when a place to document he confirmed there will any behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors when a place to document he confirmed there wany behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but assistant was a placed on the I for behaviors but as a placed on the I for behaviors but as a placed on the I for behaviors but as a placed on the I for behaviors but as a placed on the I for behaviors but as a placed on the I for behaviors but as a placed on the I for behavior but a for b	ervation on 9/28/21 at 10:10 as cooperative but was atelligible speech and holding ent Nurse and Nursing ted Resident #59 was bang her doll against the 80/21 at 9:00 AM, Nurse #1 could be combative but due she was unable to do any dent #59 often yelled out, hroughout the day. At that egan yelling in her room. It is time for her morning was going to administer her me. Nurse #1 stated there MAR to document yes or no asked to check the MAR for behaviors related to Haldol, as no place to document sumed the behaviors were	F 7	Manager initiated re-education nursing staff regarding the prochow to properly document targ behaviors and monitor for residuations. All reducation will be completed by 10/25/2021 and will not return without this re-education. Facility plan to monitor its performake sure that solutions are such a monitor sheet will be done by Administrator, DON, or design monitor and ensure that all resuprescribed psychotropic medicated target behaviors to justificand monitored appropriately. It monitoring process will take play for 4 weeks then monthly for 4. Any issues during monitoring waddressed immediately. The	cess on et dents on nursing staff to work ormance to ustained: y the ee to idents eations have y usage his ace weekly months.		
Director of Nursing (Edocumented behavior stated the target behaviors are dropped in an interview on 9/2 #1 stated target behaviored during the forecommendations revenue.	DON) stated the nurses are in the nursing notes. She aviors were yelling and are unsure how the ped off her MAR. 29/21 at 2:34 PM, Physician aviors should have been acility's monthly medication view.		to the facility Quality Assuranc Performance Improvement Co any additional monitoring or m of this plan. The QAPI Commit modify this plan to ensure the remains in substantial complia	e and mmittee for odification tee can facility nce.		
	SUMMARY ST (EACH DEFICIENC REGULATORY OR) Continued From page In a wound care obse AM, Resident #59 wa observed saying uninher doll. The Treatm Assistant (NA) #3 staknown to yell out and wall. In an interview on 9/3 stated Resident #59 to her small stature, sharm. He stated Resiscreamed and sang time, Resident #59 bo Nurse #1 stated it was medications at this time, Resident #59 bo Nurse #1 stated it was a placed on the for behaviors. When a place to document he confirmed there we any behaviors but asswhat was written on the In an interview on 9/2 Director of Nursing (Indocumented behaviors were dropped to the Information of the In	OVIDER OR SUPPLIER JS HEALTH AT ABERDEEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 In a wound care observation on 9/28/21 at 10:10 AM, Resident #59 was cooperative but was observed saying unintelligible speech and holding her doll. The Treatment Nurse and Nursing Assistant (NA) #3 stated Resident #59 was known to yell out and bang her doll against the	OVIDER OR SUPPLIER JS HEALTH AT ABERDEEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 In a wound care observation on 9/28/21 at 10:10 AM, Resident #59 was cooperative but was observed saying unintelligible speech and holding her doll. The Treatment Nurse and Nursing Assistant (NA) #3 stated Resident #59 was known to yell out and bang her doll against the wall. In an interview on 9/30/21 at 9:00 AM, Nurse #1 stated Resident #59 could be combative but due to her small stature, she was unable to do any harm. He stated Resident #59 foften yelled out, screamed and sang throughout the day. At that time, Resident #59 began yelling in her room. Nurse #1 stated it was time for her morning medications and he was going to administer her medications at this time. Nurse #1 stated there was a placed on the MAR to document yes or no for behaviors. When asked to check the MAR for a place to document behaviors related to Haldol, he confirmed there was no place to document any behaviors but assumed the behaviors were what was written on the Physician order. In an interview on 9/29/21 at 1:17 PM, the Director of Nursing (DON) stated the nurses documented behaviors in the nursing notes. She stated the target behaviors were yelling and screaming and she was unsure how the behaviors were dropped off her MAR. In an interview on 9/29/21 at 2:34 PM, Physician #1 stated target behaviors should have been identified during the facility's monthly medication recommendations review.	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 In a wound care observation on 9/28/21 at 10:10 AM, Resident #59 was cooperative but was observed saying unintelligible speech and holding her doll. The Treatment Nurse and Nursing Assistant (NA) #3 stated Resident #59 was known to yell out and bang her doll against the wall. In an interview on 9/30/21 at 9:00 AM, Nurse #1 stated Resident #59 could be combative but due to her small stature, she was unable to do any harm. He stated Resident #59 outlot be combative but due to her small stature, she was unable to do any harm. He stated Resident #59 oliging to administer her medications and he was going to administer her of the her walls. In an interview on 9/29/21 at 1:17 PM, the Director of Nursing (DON) stated the nurses documented behaviors related to Haldol, he confirmed there was no place to document any behaviors were what was written on the Physician order. In an interview on 9/29/21 at 1:17 PM, the Director of Nursing (DON) stated the nurses documented behaviors were yelling and sreaming and she was unsure how the behaviors were dropped off her MAR. In an interview on 9/29/21 at 2:34 PM, Physician #1 stated target behaviors should have been identified during the facility's monthly medication recommendations review.	OVIDER OR SUPPLIER IS HEALTH AT ABERDEEN SUMMARY STATEMENT OF DEPOPENCIES (EACH DEPOPENCY MUST RE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 In a wound care observation on 9/28/21 at 10:10 AM, Resident #59 was cooperative but was observed saying unintelligible speech and holding her doll. The Treatment Nurse and Nursing Assistant (NA) #3 stated Resident #59 was known to yell out and bang her doll against the wall. In an interview on 9/30/21 at 9:00 AM, Nurse #1 stated Resident #59 Could be combative but due to her small stature, she was unable to do any harm. He stated Resident #59 often yelled out, screamed and sang throughout the day. At that time, Resident #59 began yelling in her room. Nurse #1 stated it was time for her morning medications and he was going to administer her medications and her was going to administer her medications and her was going to a	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345509	B. WING		09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERD	EEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 758	expectation that the	e 75 ON stated it was their facility identify the need for toring when using an	F 79	58	
	facility on 2/3/20 with of 7/28/21. His diagr Lewy Bodies, seizur A psychiatry progres	s originally admitted to the a recent readmission date coses included dementia with e disorder, and depression. s note dated 7/29/21 31 was assessed as calm ted no concerns.			
	had severe cognitive wandering behavior	/1/21 indicated Resident #31 impairment. He displayed 1 to 3 days and received 7 otic medication, during the 7			
	reviewed on 8/5/21, areas: - Resident uses psyc (Seroquel) related to The interventions in occurrences of targe (pacing, wandering, response to verbal oviolence/aggression and document per fareasident is at risk for diagnosis of Lewy Bordisturbances. History	towards staff/others, etc.)			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERI	DEEN	91	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	00/00/2021
(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 APPROPR DEFICIENCY)	BE COMPLETION
F 758	into staff's legs and agitation, comments refuses to wear face included to monitor attempt to determin location, time of day situations. Documer causes. Resident #31's Sep included an order for 25 milligrams (mg) anxiety and aggress Lewy Bodies. The 67/28/21. Review of the Cons review notes for Re and September 202 monitoring targeted A review of Resider notes from 7/28/21 did not include documents from 7/28/21. Resident #31's Med Records (MAR's) froindicated he receive exhibited no behavitargeted behaviors. On 9/27/21 at 11:45 observed sitting up common area watch spoken to and appear.	story of ramming wheelchair ankles during periods of a regarding suicide and emask. The interventions behavior episodes and e underlying cause. Consider of persons involved, and int behavior and potential stember 2021 physician orders or Seroquel (an antipsychotic) by mouth twice a day for sion related to dementia with date of the original order was sultant Pharmacist medication sident #31 from August 2021 and did not reflect the need for behaviors. In #31's nursing progress to 9/29/21 was completed and amentation of any behaviors. Itication Administration or 7/28/21 to 9/29/21 and Seroquel as ordered and ors. The MAR did not list any	F 758		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345509	B. WING _			C 09/30/2021
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	DDE	00/00/2021
(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 ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIA	DATE
F 758	without behaviors of accepting of care ass Nurse #2 was intervite and stated there was monitored for Reside observed with any be documented in the nown as well as but he has not had a while. An interview was core 9/29/21 at 2:33 PM, would report if Reside behaviors or side effect Physician #1 added behavior was stable Seroquel. Physician target behaviors to be #31's antipsychotic in unaware this was nown The Unit Manager (U. 9/29/21 at 3:15 PM as behaviors were not in whether or not behavior the MAR. On 9/29/21 at 4:43 P with the Consultant F working with the facility and state of the series of	stated he currently was her than confusion and was sistance. ewed on 9/29/21 at 11:42 AM is not a specific behavior ent #31, however if he was ehaviors they would be cursing progress notes. He past Resident #31 would ed and attempt to stand up is being belligerent to staff, my negative behaviors for a serious for a mpleted with Physician #1 on who stated nursing staff ent #31 was displaying exts to a medication. Resident #31's mood and on the current dose of #1 stated he would expect to emonitored for Resident medication use and was to occurring.	F 7	758		
		1/21. He explained he ig progress notes, physician				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERI	DEEN	9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315	00/00/2021
(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 APPROPR DEFICIENCY)	BE COMPLETION
F 758	and psychiatric progrespecific behaviors in medications. He ad accomplished with shehaviors were preserved medications were preserved medication and ally basis. The Director of Nursy/30/21 at 12:39 PN expectation for the smonitoring need for symptoms for the usual section of the usual section of the usua	gress notes to monitor for elated to antipsychotic dded monitoring was staff documentation when sent, and he would not have et behaviors to be monitored sing was interviewed on and stated it was her staff to identify Resident #31's targeted behavioral se of Seroquel. as admitted to the facility on ses that included vascular vioral disturbance, insomnia, d depressive disorder. as note dated 9/14/21 #63 was talkative and at his es were noted. a Data Set (MDS) assessment ated Resident #63 was id had no behaviors. He an antipsychotic medication,	F 758		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345509	B. WING		C 09/30/2021	
	ROVIDER OR SUPPLIER US HEALTH AT ABER	DEEN	9	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD ABERDEEN, NC 28315	1 00/00/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 758	during periods of ac included to monitor attempt to determin location, time of day situations. Docume cause. Resident #63's Sepincluded an order for 75 milligrams (mg) agitation related to behavioral disturbatorder was 5/14/21. Review of the Constreview notes for Resultil September 20 monitoring targeted A review of Resider notes from 5/14/21 revealed behaviora 2021 and Septemb staff members, call of using call light, in towards staff members for assistance with the received exhibited no behaviors.	s racial slurs towards staff gitation. The interventions behavior episodes and le underlying cause. Consider ly, persons involved and le underlying cause. Consider le la	F 758			
	observation of Resi	dent #63 occurred. He was in bed watching TV. He was I he preferred to spend most				

COMPLETED		A. BUILDING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		
C 09/30/2021		B. WING	345509		
30/00/2021	EET ADDRESS, CITY, STATE, ZIP CODE PEE DEE ROAD RDEEN, NC 28315		EEN	PROVIDER OR SUPPLIER	
(X5) COMPLETION DATE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ID PREFIX TAG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENC	(X4) ID PREFIX TAG
		F 75	ewed on 9/29/21 at 11:45 AM not a specific behavior nt #63, however if he was haviors they would be ursing progress notes. haviors were displayed by #1 stated "mostly agitation" ovide specific behaviors. **npleted with Physician #1 on who stated nursing staff ent #63 was displaying exts to a medication. He would expect target stored for Resident #63's stion use and was unaware gl. **M) was interviewed on and confirmed target into itored on the MAR just itors were present at the time stration by marking yes or **M, an interview occurred harmacist, who started ty September 2021 and had eccent medication review for 1/21. He explained he g, physician, and psychiatric nitor for specific behaviors itic medications. He added	of his time in bed wat Nurse #1 was intervie and stated there was monitored for Resider observed with any be documented in the nu When asked what be Resident #63, Nurse and was unable to pre An interview was com 9/29/21 at 2:33 PM, v would report if Reside behaviors or side effe Physician #1 stated h behaviors to be monit antipsychotic medicat this was not occurring The Unit Manager (U 9/29/21 at 3:15 PM at behaviors were not m whether or not behav of medication adminis no. On 9/29/21 at 4:43 PI with the Consultant P working with the facilit completed the most m Resident #63 on 9/22 referred to the nursing progress notes to mo related to antipsychological	F 758
			not a specific behavior nt #63, however if he was haviors they would be ursing progress notes. haviors were displayed by #1 stated "mostly agitation" ovide specific behaviors. Inpleted with Physician #1 on who stated nursing staff ent #63 was displaying ects to a medication. He would expect target stored for Resident #63's stion use and was unaware g. M) was interviewed on and confirmed target conitored on the MAR just iors were present at the time stration by marking yes or M, an interview occurred harmacist, who started ty September 2021 and had ecent medication review for #21. He explained he g, physician, and psychiatric nitor for specific behaviors ice medications. He added	and stated there was monitored for Resider observed with any be documented in the nu When asked what be Resident #63, Nurse and was unable to provide the provided of the prov	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345509	B. WING _			C 09/30/2021
	ROVIDER OR SUPPLIER	EEN		STREET ADDRESS, CITY, STATE, ZIP CO 915 PEE DEE ROAD ABERDEEN, NC 28315	DE	03/30/2021
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIA	DATE
F 758	Continued From pag	e 81	F 7	758		
	9/30/21 at 12:39 PM expectation for the simonitoring for targete the use of Seroquel. 4. Resident #53 was 5/7/2021 with most resident #53/2021. Her admit osteomyelitis (bone in the lower lumbar regalisorder. Resident #53's admit (MDS) dated 9/7/202 cognitively impaired disorganized thinking extensive assistance (ADL) and received as	and stated it was her taff to identify Resident #63's ed behavioral symptoms for admitted to the facility on ecent readmission on ting diagnoses included infection) of the vertebrae in ion, and major depressive ession Minimum Data Set indicated she was severely with behaviors positive for g. Resident #53 required with activities of daily living antipsychotic medications 7 pressants 7 out of 7 days,				
	assessment period. A review of Resident updated on 8/30/202 focus area: "Resident uses prelated to disease prelated to disea	#53's care plan, last 1, revealed the following sychotropic medications ocess, major depressive httpsychotic and cations. Interventions psychotropic medications as . Monitor for side effects and shift and consult with				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED
		345509	B. WING		C 09/30/2021
	ROVIDER OR SUPPLIER US HEALTH AT ABERI	DEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	1 00/00/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 758	Resident #53's Aug Medication Administrevealed an order for (mg) at bedtime for with a start date of list target behaviors the behaviors were On 9/29/21 at 4:31g conducted with NA with Resident #53 at When asked about related to antipsychnot sure but she thoresident crawled out not sure where to fibehaviors. On 9/29/2021 at 4:30g conducted with NA with an agency but #53 on 9/29/2021 at her. She stated she resident's target be know where to find Resident #53. On 9/29/21 at 4:33g conducted with Nur	ust 2021 and September 2021 tration Record (MAR) or Seroquel 150 milligrams major depressive disorder 8/27/2021. The MARs did not or any area to document if present. om and interview was #7. She stated she did work and was familiar with her. behaviors being monitored notic use, she stated she was ought it might be that the it of bed sometimes. She was nd Resident #53's targeted 82pm an interview was #8. She stated she worked she was assigned to Resident nd somewhat familiar with e did not know what the haviors were and she did not a list of target behaviors for	F 75	,	
	asked about target related to the use o was new to the faci Resident #53's targ them. She further s	nt #53 on 9/29/2021. When behaviors being monitored f Seroquel, she stated she lity and she did not know et behaviors or where to find tated she has observed the people who are not in the			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345509	B. WING		l	30/2024
	ROVIDER OR SUPPLIER US HEALTH AT ABERDE	l		STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	<u> 09/</u>	30/2021
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758 F 808 SS=E	with the Consultant P working with the facilit completed Resident # medication review on referred to the nursing notes, and psychiatric for specific behaviors medications. He furth accomplished with stabehaviors were preserved a daily basis. The director of nursing 9/30/2021 at 12:39pn expectation for staff to	pm an interview occurred harmacist who started ty September 2021. He #53's most recent 9/22/2021. He explained he g progress notes, physician c progress notes to monitor related to antipsychotic er stated monitoring was aff documentation when ent, and he would not have behaviors be monitored on g was interviewed on and stated it was her o identify the targeted associated with the use of scribed by Physician (2)	F 7			10/26/21
	delegate to a register task of prescribing a retherapeutic diet, to the law. This REQUIREMENT by: Based on observation Therapist (ST), Register	tending physician may ed or licensed dietitian the resident's diet, including a e extent allowed by State is not met as evidenced n, facility staff, Speech stered Dietitian (RD) and interviews and record		F-808 This plan of correction constitutes a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDII			, ا	c
		345509	B. WING _				30/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				91	15 PEE DEE ROAD		
ACCORD	US HEALTH AT ABERDE	EEN		Α	BERDEEN, NC 28315		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 808	Continued From page	e 84	F 8	308			
	review, the facility fail	led to clarify oral dietary			written allegation of compliance.		
	recommendations an	d obtain dietary Physician			Preparation and submission of this pla	n of	
		with a feeding tube. This			correction does not constitute an		
	,	32) of 1 residents reviewed			admission or agreement by the provide	er of	
	for tube feeding. The findings included:				the truth of the facts or alleged, or the		
					correctness of the conclusions set forth	•	
	Resident #32 was admitted on 12/21/18 with a				on the statement of deficiencies. This p		
	diagnosis of a Cerebral Vascular Accident and a				of correction is prepared and submitted		
	feeding tube.				solely because of the requirement und state and federal law and to demonstra		
	An ST Evaluation and	d Plan of Treatment dated			the good faith attempts by the provider		
	12/10/20 read Resident #32 was referred to ST				improve the quality of life of each resid		
	services due to mild oral dysphagia as evidenced						
	by prolonged mastication. His diet at the time of				Root Cause:		
	the evaluation was regular texture with thin						
	liquids. Resident received additional nutritional				The Administrator and the Director of		
	support via his feedin	ig tube.			Nursing discussed with the IDT QAPI		
					committee team on 9/30/2021 to identi	fy	
		ımmary dated 1/25/21 read			the root cause of this alleged		
	his long-term goal wa				non-compliance. Root cause analysis		
	I .	s unchanged. Resident #32			conducted revealed that the alleged		
	was to receive a regu	ılar diet with thin liquids.			non-compliance resulted from inadequ		
	A DD	data d O/E/O4 mand Danidamt			training/understanding of the nursing s	ιаπ	
		dated 2/5/21 read Resident weight change of 7.5%			regarding clarification of oral dietary recommendations and to obtain dietary	,	
		s. The note read there was			physician orders for a resident with a	'	
	,	nical soft diet and the ST			feeding tube.		
		t #32 was ordered a regular			, , , , , , , , , , , , , , , , , , , ,		
	diet. The mechanical discontinued.	•			For affected resident(s):		
					Resident #32 had oral dietary orders		
	An RD progress note	dated 2/26/21 read			clarified by the speech therapist on	ĺ	
	Resident #32's food trays were discontinued and				9/28/2021.		
		increased to continuous with					
		up by mouth three times			For other residents with the potential to	be	
	daily. This was due to 10% weight loss in 180				affected:	ĺ	
	•	mended a pleasure tray if					
	cleared by ST.				An audit (title: f-808) was completed fo		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345509	B. WING _		0:	C 9/ 30/2021	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
				915 PEE DEE ROAD			
ACCORDIUS HEALTH AT ABERDEEN				ABERDEEN, NC 28315			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 808	Continued From page	e 85	F 8	08			
	An RD progress note			9/30/2021. No other residents	are		
		significant weight gain of		receiving tube feeding at this t			
		note read his continuous		systemic changes stated below			
		iscontinued and now to be		put in place to prevent any risk			
	administered every 4 hours. He was still			additional residents.			
	receiving the frozen nutritional cup.						
	J	•		Facility plan to prevent re-occu	urrence:		
	An RD progress note	dated 5/17/21 read					
	Resident #32 was again prescribed continuous			To protect residents from simil	ar		
	tube feeding with a frozen nutritional cup three			occurrences, on 10/13/2021 th			
	times daily. The note read to continue the plan of			Staff Development Coordinato			
	care and the RD would continue to monitor.			Manager initiated re-education			
				nursing staff along with Dietary			
	RD notes dated 6/14/21 and 7/30/21 read there			regarding the process on how			
	_	Resident #32's dietary		obtain clarification of an oral d	-		
		ntinue to receive a frozen		recommendations and to obtain			
		imes daily along with his		corresponding dietary physicia			
	continuous tube feed	ing.		a resident with a feeding tube. staff education will be complet			
	Resident #32's quart	erly Minimum Data Set		10/25/2021 and will not return			
		ndicated severe cognitive		without this re-education.	to work		
		xhibited no behaviors. He		Without the 10 Sudducti.			
	was coded for total a			Facility plan to monitor its perf	ormance to		
		g. Review of section K		make sure that solutions are s			
	_	al Status) indicated he was					
	not coded for the nut	ritional approach of his		A monitor sheet will be done b	y the		
		coded for any nutrition taken		Administrator, DON, or design	ee to		
	by mouth.			monitor and ensure that all res	idents on a		
				feeding tube have the needed	clarification		
		dated 8/12/21 read there		of oral dietary recommendation			
		sident #32's continuous tube		obtain corresponding dietary p			
	_	nutritional cup, but the new		orders for a resident with a fee	•		
		s for Resident #32 to receive		This monitoring process will ta			
	a pleasure tray.			weekly for 4 weeks then montl months.	nly for 4		
	Resident #32's Septe	ember 2021 Physician orders					
		ted 8/11/21 for a mechanical		Any issues during monitoring v	will be		
		thin liquids and an order for		addressed immediately. The			
		up three times daily dated		Administrator, DON, or design	ee will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345509	B. WING _			l	30/2021
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN				91	IREET ADDRESS, CITY, STATE, ZIP CODE 15 PEE DEE ROAD BERDEEN, NC 28315	1 037	50/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 808	9/2/21 for tube feeding support. An RD progress note #32 may receive a plantritional cup by mo recommendations relevant with the received and	a dated 9/3/21 read Resident easure tray and a frozen uth. There were no new lated to his tube feeding. feeding care plan last revised quired a feeding tube related to receive pleasure 9/27/21 at 11:39 AM, ng in bed with the head of pproximately 45 degrees. running continuously as 28/21 at 11:00 AM, the DON) stated Resident #32 supplement by mouth and (nothing by mouth). The eptember 2021 Physician order dated 8/11/21 for a with thin liquids. She stated at receiving a mechanical soft explain why Resident #32	F	808	report findings of the monitoring proces to the facility Quality Assurance and Performance Improvement Committee 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 10/26/2021	for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	COMPLETED	
		345509	B. WING		C 09/30/2021	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN				STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315	03/30/2021	
(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 808	given the frozen nu He stated he had n dietary communicat 2/17/21 for the froze In an interview on 9 stated Resident #32 severe dysphagia. communication form mechanical soft die reviewed by the ME that form and it was In an interview on 9 stated she stated sh Resident #32 was r She stated she was #32 yesterday (9/28 swallow study. Bas Resident #32 displa symptoms of aspira when food or liquid goes below the voor when food or liquid stays above the voor recommended a me liquids and tapering stated the DON and develop a tube feed ST stated she watc breakfast this morn without any problem In a telephone inter the RD stated she r yesterday (9/28/21) Resident #32 diet of	critional cups three times daily. The received any additional cion forms except one dated en nutritional supplement. 29/21 at 10:32 AM, the MD 2 should be NPO due to his A copy of the dietary in dated 9/28/21 for the with thin liquids was anot signed by him. 29/21 at 12:15 PM, the ST in the was not aware that not getting his dietary trays. It is asked to evaluate Resident (3/21) and completed a bedside end on the swallow study, anyed no overt signs or tion/penetration. (Aspiration is goes into the trachea and all cords while penetration is goes into the trachea but call cords). The ST stated she exchanical soft diet with thin of his tube feedings. She if RD were working together to ding tapering schedule. The hed Resident #32 eat his ling and he consumed 25% ins.	F 80			
	stated Resident #32 severe dysphagia. communication form mechanical soft die reviewed by the ME that form and it was In an interview on 9 stated she stated she stated she stated she was #32 yesterday (9/28 swallow study. Bas Resident #32 displa symptoms of aspira when food or liquid goes below the voor when food or liquid stays above the voor recommended a meliquids and tapering stated the DON and develop a tube feed ST stated she watch breakfast this morn without any problem. In a telephone inter the RD stated she reyesterday (9/28/21) Resident #32 diet of Resident #32 was reviewed.	2 should be NPO due to his A copy of the dietary in dated 9/28/21 for t with thin liquids was b. He stated he had never saw is not signed by him. 1/29/21 at 12:15 PM, the ST he was not aware that not getting his dietary trays. Is asked to evaluate Resident 1/21) and completed a bedside ed on the swallow study, hyed no overt signs or tion/penetration. (Aspiration is goes into the trachea and al cords while penetration is goes into the trachea but cal cords). The ST stated she echanical soft diet with thin of his tube feedings. She d RD were working together to ding tapering schedule. The hed Resident #32 eat his ing and he consumed 25% his. View on 9/29/21 at 2:52 PM, eccived a call from the facility for clarification about				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345509	B. WING			C	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT ABERDEEN				STREET ADDRESS, CITY, STATE, ZIP COD 915 PEE DEE ROAD ABERDEEN, NC 28315		09/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 808	The RD stated she we dated 8/11/21 for a m stated she visited the after each visit, she e recommendations to and the DON to obtai orders. The RD stated that Resident #32 was supplement by mouth In an interview on 9/2 Development Coordin other UM who recentl was a problem with R She stated they recei 8/11/21 that he should soft diet with thin liqui possible that she nor complete a dietary cothe dietary departmer. In an interview on 9/3 Administrator and DC expectation that Residents.	as unaware of the order echanical soft diet. The RD facility twice monthly and mailed her the Unit Managers (UMs) in any needed Physician dishe only learned yesterday is only receiving a frozen in the Unit Managers (UMs) in any needed Physician dishe only learned yesterday is only receiving a frozen in the Unit Managers (UMs) in any needed Physician dishe only learned yesterday is only receiving a frozen in the Unit Managers (UMs) in any needed here esident #32's diet orders. Wed clarification orders on the Unit Managers (UMs) in any needed here esident #32's diet orders. Wed clarification orders on the Unit Managers (UMs) in any needed here esident #32's diet orders. Wed clarification orders on the Unit Managers (UMs) in any needed here esident #32's diet orders. Wed clarification orders on the Unit Managers (UMs) in any needed Physician dietary and accurate and Resident mail to the Unit Managers (UMs) in any needed Physician dietary and accurate and Resident mail to the Unit Managers (UMs) in any needed Physician dietary and accurate and Resident mail to the Unit Managers (UMs) in any needed Physician dietary and accurate and Resident mail to the Unit Managers (UMs) in any needed Physician dietary and accurate and Resident mail to the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Managers (UMs) in any needed Physician dietary and the Unit Mana	F	308			