	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345063	B. WING		11/04/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT WILSO	Ν		1804 FOREST HILLS ROAD W WILSON, NC 27893	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 000	INITIAL COMMENT	S	F 000		
F 684	-	-	F 684		12/3/21
SS=D	CFR(s): 483.25 § 483.25 Quality of c Quality of care is a f	care undamental principle that ent and care provided to			
	assessment of a res that residents receiv accordance with pro practice, the compre- care plan, and the re This REQUIREMEN	sed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of chensive person-centered esidents' choices. T is not met as evidenced			
	facility failed to comp dressing changes as	view and staff interviews the olete non-pressure wound s ordered by the physician for ewed for wound care		The Plan of correction is not to be construed as an admission of any wro doing or liability. The facility reserves rights to contest the survey findings through informal dispute resolution, for appeal proceedings or any administra	the
	4/15/21 with a diagn	d: mitted to the facility on osis of type 2 diabetes er and peripheral vascular		or legal proceedings. This plan of correction is not meant to establish an standard of care, contract obligation of position and the facility reserves all rig to raise all possible contentions and defenses in any type of civil or crimina	ny or ghts
	revealed Resident # impairment. He nee	um Data Set dated 7/28/21 9 had moderate cognitive ded extensive assistance ansfers, and toilet use.		claim, action or proceeding. Nothing contained in this plan of correction she be considered as a waiver of any potentially applicable Peer Review, Q assurance or self-critical examination privilege which the facility does not wa	uality

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/02/20 RM APPROVE IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			· · ·	E SURVEY IPLETED
		345063	B. WING _			1	1/04/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILSON				04 FOREST HILLS ROAD W ILSON, NC 27893		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 684	Resident #9 ' s care p revealed he was care impairment to skin int the right foot/toes. A review of the physic revealed the following Cleanse right medial cleanser, apply a deb cover with dry gauze, secure with tape ever Start date was 7/24/2 A review of the treatm revealed this dressing documented as comp An interview was con PM on 11/3/21. She working the hall Resid she did not do the dre #9 because she was day shift and couldn ' An interview was con Director of Nursing or stated since arriving t implemented more st speak for the previous expected dressing ch ordered for any reside	blan updated 8/18/21 planned for actual egrity/non-pressure ulcer of cian orders for Resident #9 g orders: first toe with wound riding agent to wound bed, wrap with rolled gauze and y day shift for wound care. 1. hent administration record g change was not leted on 9/18/21. ducted with Nurse #1 at 4:15 stated on 9/18/21 she was dent #9 resided. She stated essing change for Resident the only nurse working the t get to them all. ducted with the interim h 11/4/21 at 11:35 AM. He o the facility he had aff. He stated he could not is administration, but he anges to be completed as ent. He also stated staff d he would do the dressing	F	584	 and reserves the right to assert in administrative, civil or criminal clai action or proceeding. The facility of response, credible allegations of compliance and plan of correction of its ongoing efforts to provide quicare to residents F684 Quality of Care Resident #9 was discharged facility on 11/3/21. Employee was employee and has not been at facility on 11/3/21, the Regional Di Clinical Services (RDCS) complet audit of the Treatment Administrat Records (TAR) from 11/06-11/22/2 residents with current non-pressure wound treatment orders for complitreatments as ordered. No advers outcomes to other residents identi Beginning 11/22-12/2/21, the of Nursing (DON) provided educar current facility and agency license nurses on administration and documentation of non-pressure we per physician orders. The licensed will continue to administer treatment ordered and document on the TAF omission. The DON will monitor tr administration records during daily meeting via PCC dashboard report ordered. Discrepancies will be additioned to the presence ordered. 	in, offers its as part ality of from the Agency ility rector of ed an ion 21 for re etion of e fied. Director tion to d Director tion to d ounds a nurse ents as R without eatment / clinical t to ded as	

Event ID: KO9O11

Facility ID: 922960

If continuation sheet Page 2 of 18

CENTER STATEMENT (AND PLAN OF NAME OF PI	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345063	, í	LE CONSTRUCTION	FORM OMB NC (X3) DATE COMP	D: 12/02/2021 MAPPROVED D: 0938-0391 SURVEY LETED C 04/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WILSON, NC 27893 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684 F 686 SS=D	CFR(s): 483.25(b)(1)(§483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre- resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indi- demonstrates that the (ii) A resident with pre- necessary treatment a with professional stand	event/Heal Pressure Ulcer i)(ii) rity re ulcers. hensive assessment of a nust ensure that- care, consistent with s of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent dards of practice, to rent infection and prevent	F 68	 education upon hire. 4) The Director of Nursing and/or licensed nurse supervisor will complet audit of five (5) residents with non-pressure wounds for documentati per the TAR of treatments as ordered the physician. Monitoring will be completed at a frequency of five (5) tir weekly for two (2) weeks, then 3 time: weekly for four (4) weeks and as necessary thereafter. The Administrate will report findings of the monitoring to Interdisciplinary Team (IDT) during QA meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with quality of care. 5) Date of Compliance 12/3/2021 	on by nes s or the vPI	12/3/21

If continuation sheet Page 3 of 18

CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES	-1			D: 12/02/2021 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COM	E SURVEY PLETED C
		345063	B. WING			/04/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILSON		1	804 FOREST HILLS ROAD W		
ACCORDI	US HEALTH AT WILSON		v	VILSON, NC 27893		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 686	by:	is not met as evidenced	F 686			
	interviews the facility wound dressing chan	ew, staff, and resident failed to complete pressure ges as ordered by the sidents reviewed for wound		 F686 Treatment/Svs to Prevent /H Pressure Ulcer 1) Resident #8 continues to rece treatments to pressure wounds as ordered by the physician however 	ive	
	The findings included Resident #8 was adm 10/10/20. His diagno	itted to the facility on		times non-compliant. Nurse is Age Nurse and has not been here since (Same Nurse as in Tag 684)	ncy	
	pressure ulcers and o The annual Minimum 10/7/21 revealed Res intact. He required su toilet use and was ind	-		2) On 11/22/21, the Regional Dirr Clinical Services (RDCS) complete audit of the Treatment Administration Records (TAR) from 11/06-11/22/2 residents with current pressure wo treatment orders for completion of treatments as ordered. No adverse outcomes to other residents identif	ed an on 1 for und	
	ulcers and was at risk pressure ulcers. A review of the physic revealed the following a. Order dated 5/21/2 thigh with wound clea wound healing) wound	ted with multiple pressure for development of further tian orders for Resident #8 orders: 21 cleanse right posterior nser, apply collagen (aids in d powder to wound bed,		3) Beginning 11/22-12/2/21, the I of Nursing (DON) provided educati current facility and agency licensed nurses on administration and documentation of pressure wounds physician orders. The licensed nur continue to administer treatments a ordered and document on the TAR omission. The DON will monitor tre administration records during daily meeting via PCC dashboard report	on to b s per se will as without eatment clinical to	
	absorbent dressing and day shift. Order was of b. Order dated 5/21/2 wound cleanser, apply necrotic area of wound	21 cleanse sacrum with		ensure treatments are being provided ordered. Discrepancies will be add as appropriate. Newly hired facility agency licensed nurses to receive education upon hire.	ressed	

Facility ID: 922960

If continuation sheet Page 4 of 18

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/02/2021 MAPPROVED D: 0938-0391
STATEMENT OF AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		SURVEY PLETED
		345063	B. WING				04/2021
NAME OF PRO	OVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
	S HEALTH AT WILSON			18	304 FOREST HILLS ROAD W		
ACCONDIO	STIEZENTAT WIESON			W	/ILSON, NC 27893		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Order was discontinue c. Order dated 5/21/2 would cleanser, apply with dry dressing, thic secure with tape ever d. Order dated 521/2 wound cleanse, apply wound bed, cover with dressing, thick absorb and secure with tape e. Order dated 6/30/2 to scrotum topically er care. Order dated 7/30/2 wound cleanser, apply pad and secure with t A review of the treatm revealed the pressure were not documented Resident #8 was inter He stated he couldn ' dressing change on 9 weekend it probably of An interview was cone PM on 11/3/21. She s working the hall Resid she did not do the dre #8 because she was f day shift and couldn ' An interview was cone Director of Nursing or stated since arriving to	with tape every day shift. ed 10/11/21. 21 cleanse left ischium with 7 a debriding agent, cover 5k absorbent dressing and 9 day shift. 1 cleanse right calf with 9 collage wound powder to 6h debriding agent, dry 9 bent dressing, rolled gauze every day shift. 21 apply a topical antibiotic very day shift for wound ontinued 10/4/21 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse are right ischium with 9 a debriding agent, ABD ape every day shift. 1 cleanse agent, agent 9 a debriding agent, agent 9 a debriding agent, agent 9 a debriding agent 9 a d	F	586	 4) The Director of Nursing and/or licensed nurse supervisor will compleaudit of five (5) residents with pressure wounds for documentation per the TA treatments as ordered by the physical Monitoring will be completed at a frequency of five (5) times weekly for (2) weeks, then 3 times weekly for for (4) weeks and as necessary thereafted the Administrator will report findings the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary maintain compliance with treatment a services to prevent and/or heal press wounds. 5) Date of Compliance 12/3/ 	re AR of an. two ur er. of any to and sure	

If continuation sheet Page 5 of 18

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345063	B. WING				C 04/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILSON				804 FOREST HILLS ROAD W /ILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 686 F 725 SS=D	expected dressing ch ordered for any reside could come to him an changes himself if ne Sufficient Nursing Sta	anges to be completed as ent. He also stated staff d he would do the dressing eded. ff		686 725			12/3/21
	§483.35(a) Sufficient The facility must have the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res- resident assessments and considering the re- diagnoses of the facili	Staff. sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care					
	by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed	onnel, including but not					
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on record revi	section, the facility must nurse to serve as a charge			F725 Sufficient Nursing Staff		

Facility ID: 922960

If continuation sheet Page 6 of 18

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345063	B. WING		C 11/04/2021
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	·
ACCORD	US HEALTH AT WILSON			1804 FOREST HILLS ROAD W	
ACCORD	US REALTH AT WILSON		,	WILSON, NC 27893	
(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)	LD BE COMPLETION
F 725	complete dressing ch physician to 2 of 2 re- reviewed for pressure and Resident #9 for r dressing change). Finding included: Cross refer to F686: I staff, and resident int complete pressure we ordered by the physic reviewed for wound of Cross refer to F684: staff interviews the fa non-pressure wound ordered by the physic reviewed for wound of An interview was con Director of Nursing of stated since arriving to implemented more st speak for the previou expected dressing ch ordered for any reside	hanges as ordered by the sidents. (Resident #8 e wound dressing change hon-pressure wound Based on record review, erviews the facility failed to ound dressing changes as cian for 1 of 2 residents care (Resident #8). Based on record review and cility failed to complete dressing changes as cian for 1 of 2 residents care (Resident #9). ducted with the interim in 11/4/21 at 11:35 AM. He to the facility he had aff. He stated he could not is administration, but he hanges to be completed as ent. He also stated staff ind he would do the dressing	F 725	 1.) On 1/24/21 Administrator and I completed a review of sufficient state coverage for facility based on cense acuity. Cross refer to F684: Resident #9 continued to receive treatments to toe diabetic wound as ordered by the physician and was discharged from facility on 11/3/21. Cross refer to F686: Resident #8 continues to receive treatments to pressure wounds as ordered by the physician and continues to refuse treatments at times per non-complicate plan 2.) On 11/23/2021 facility contrate Agency treatment Nurse as we conto advertise and interview for Wour Nurse. Cross refer F684: On 11/22/21, the Regional Director of Clinical Servic (RDCS) completed an audit of the Treatment Administration Records from 11/06-11/22/21 for residents we current non-pressure wound treatments or dered. No adverse outcomes to coresidents identified. Cross refer F686: On 11/22/21, the Regional Director of Clinical Servic (RDCS) completed an audit of the Treatment Administration Records from 11/06-11/22/21 for residents we current non-pressure wound treatments or dered. No adverse outcomes to coresidents identified. Cross refer F686: On 11/22/21, the Regional Director of Clinical Servic (RDCS) completed an audit of the Treatment Administration Records from 11/06-11/22/21 for residents we current non-pressure wound treatments or dered. No adverse outcomes to coresidents identified. 	<pre>ffing us and right he n the ance cted an tinue hd es (TAR) //th hent as other es (TAR) //th </pre>

Event ID: KO9O11

Facility ID: 922960

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FXTENENT OF DEFICIENCIES (X1) PROVIDERENUEIRCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) DATE SIPPLY COMPLETED NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT WILSON STREET ADDRESS. CITY. STATE. JP CODE 1804 FOREST HILLS ROAD W WILSON, NC 27893 STREET ADDRESS. CITY. STATE. JP CODE 1804 FOREST HILLS ROAD W WILSON, NC 27893 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER FLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG FOODERF FLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG FOODERF FLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG FOODERF FLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG FOODERF FLAN OF CORRECTION (EACH OERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG FOODERF FLAN OF CORRECTION (EACH OERCIENCY) COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIENCY COMP		-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/02/2021 FORM APPROVED OMB NO. 0938-0391
345063 B. WING 11/04/2021 INMEL OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZP CODE 11/04/2021 ACCORDIUS HEALTH AT WILSON Interest address, GTY, STATE, ZP CODE 11/04/2021 (Maj ID PREPIX SUMMARY STATEMENT OF DEFICIENCIES (EACH ORDERST HALLS ROAD W WILSON, NC 27893 Interest address addres address address addres address address addres addre	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, UT, STATE, ZIP CODE ACCORDIUS HEALTH AT WILSON If the FADDRESS FLAN OF CORRECTION O(4) ID PREFX SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LISC DENTIFYING INFORMATION) IP PREFX PROVIDERS FLAN OF CORRECTIVE ACTION BHOLD BE (EACH ODRECTIVE ACTION BHOLD BE CORRECTIVE ACTION BHOLD BE DEFICIENCY) Or CONRECTIVE ACTION BHOLD BE (EACH ODRECTIVE ACTION BHOLD BE DEFICIENCY) Or CONRECTIVE ACTION DEFICIENCY F 725 Continued From page 7 F 725 for completion of treatments as ordered. No adverse outcomes to other residents identified. 3) Administrator provided reeducation to the Scheduler on scheduling and monitoring requirements to ensure sufficient nursing staff and provided education to the process of posting/renewing job ads and monitoring and scheduling applicants to fill any open nursing positions. Newly hired Schedulers and ABOMs will receive education upon hire. The scheduler will continue to scheduler according to censure sufficient nursing staff and provided education to the process of posting/renewing job ads and monitoring and scheduling applicants to fill any open nursing positions. Newly hired Schedulers and ABOM will receive education upon hire. The scheduler will continue to schedule according to censure sufficient staffing each day based on census and aculty and recruit and hire to fill any open nursing positions to ensure sufficient staffing each day based on census and aculty and recruit and retain staff as needed.			345063	B. WING _		-
ACCORDUS HEALTH AT WILSON WILSON, NC 27833 Image: Construct of the construction of the con	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
(K4) 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 CORRECTIVE ACTION SHOULD BE CROSS-REPROEND TO THE APPROPRIATE DEFICIENCY) (COMPLETION DATE F 725 Continued From page 7 F 725 for completion of treatments as ordered. No adverse outcomes to other residents identified. 3) Administrator provided reeducation to the Scheduler on scheduling and monitoring requirements to ensure sufficient nursing staff and provided education to the Assistant Business Office Manager (ABOM) on the process of postimum version of the schedulers and ABOMs will receive education upon hire. The scheduler will continue to schedule according to census and acuity and the ABOM will receive administrator multipation of the schedule and applicants to fill any open nursing positions. Newly hired Schedulers sufficient nurse staffing. The Administrator will monitor the schedule and applicant flow daily to ensure sufficient nurse staffing. The Administrator will monitor the schedule and applicant flow daily to ensure sufficient staffing and acuity and recruit and here to fill any open nursing positions. Newly hired Scheduler and applicant flow daily to ensure sufficient staffing the and acuity and recruit monitor the schedule and applicant flow daily to ensure sufficient staffing reach day based on census and acuity and recruit and retain staff as needed.	ACCORDI	US HEALTH AT WILSON				
Prefrix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERDED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 725 Continued From page 7 F 725 for completion of treatments as ordered. No adverse outcomes to other residents identified. 3) Administrator provided reeducation to the Scheduler on scheduling and monitoring requirements to ensure sufficient nursing staff and provided education to the Assistant Business Office Manager (ABOM) on the process of posting requirements to fill any open nursing positions. Newly hired Schedulers and ABOM will receive education upon hire. The schedule according to census and acuity and the ABOM will receive aduction upon hire. The schedule according to census and acuity and the ABOM will recruit and hire to fill any open nursing positions to ensure sufficient nurse staffing. The Administrator will monitor the schedule and applicant flow daily to ensure sufficient staffing ach day based on census and acuity and recruitment for open positions and will implement strategies to recruit and retain staff as needed.						
for completion of treatments as ordered. No adverse outcomes to other residents identified. 3) Administrator provided reeducation to the Scheduler on scheduling and monitoring requirements to ensure sufficient nursing staff and provided education to the Assistant Business Office Manager (ABOM) on the process of posting/renewing job ads and monitoring and scheduling applicants to fill any open nursing positions. Newly hired Schedulers and ABOMs will receive education upon hire. The scheduler will continue to schedule according to census and acuity and the ABOM will recruit and hire to fill any open nursing positions to ensure sufficient nurse staffing. The Administrator will monitor the schedule and applicant flow daily to ensure sufficient staffing each day based on census and acuity and recruit and retain staff as needed.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE COMPLETION
(DON) provided education to current facility and agency licensed nurses on administration and documentation of non-pressure wounds per physician orders. The licensed nurse will continue to administer treatments as ordered and document on the TAR without omission. The DON will monitor treatment administration records during daily clinical	F 725	Continued From page	2.7	F 7	 25 for completion of treatments as on No adverse outcomes to other relidentified. 3) Administrator provided reeds the Scheduler on scheduling and monitoring requirements to ensure sufficient nursing staff and provide education to the Assistant Busine Manager (ABOM) on the process posting/renewing job ads and monad scheduling applicants to fill a nursing positions. Newly hired Sc and ABOMs will receive education hire. The scheduler will continue schedule according to census an and the ABOM will recruit and hir any open nursing positions to ensufficient nurse staffing. The Administrator will monitor the sch and applicant flow daily to ensure sufficient staffing each day based census and acuity and recruitme open positions and will implement strategies to recruit and retain staneeded. Cross refer F684: Beginning 11/22-12/2/21, the Director of Nu (DON) provided education to currifacility and agency licensed nurse administration and documentatio non-pressure wounds per physic orders. The licensed nurse will condiminister treatments as ordered document on the TAR without on The DON will monitor treatment 	esidents ucation to re led ess Office s of onitoring any open chedulers on upon to d acuity re to fill sure hedule e d on nt for nt aff as rsing rent es on n of ian ontinue to d and hission.

Event ID: KO9O11

Facility ID: 922960

If continuation sheet Page 8 of 18

	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345063	B. WING _		11/04/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
ACCORD	US HEALTH AT WILSON	I		1804 FOREST HILLS ROAD W WILSON, NC 27893	
(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 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 725	Continued From page	e 8	F 7	 P25 ensure treatments are beir ordered. Discrepancies will as appropriate. Newly hire agency licensed nurses to education upon hire. Cross refer F686: Beginnir 11/22-12/2/21, the Director (DON) provided education facility and agency license administration and docume pressure wounds per phys The licensed nurse will cor administer treatments as o document on the TAR with The DON will monitor treat administration records duri meeting via PCC dashboa ensure treatments are beir ordered. Discrepancies wil as appropriate. Newly hire agency licensed nurses to education upon hire. Cross refer F684: The Dire and/or licensed nurse sup complete an audit of five (§ non-pressure wounds for o per the TAR of treatments the physician. Monitoring w completed at a frequency of weekly for two (2) weeks, five weekly for four (4) weeks necessary thereafter. The will report findings of the m Interdisciplinary Team (IDT meetings monthly for three and will make changes to a necessary to maintain com 	Il be addressed ad facility and receive ng r of Nursing to current ad nurses on entation of sician orders. ntinue to ordered and nout omission. tment ing daily clinical rd report to ng provided as Il be addressed ad facility and receive ector of Nursing ervisor will 5) residents with documentation as ordered by will be of five (5) times then 3 times and as Administrator nonitoring to the T) during QAPI e (3) months the plan as

Event ID: KO9O11

Facility ID: 922960

If continuation sheet Page 9 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2021 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345063	B. WING				C 04/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILSON				804 FOREST HILLS ROAD W /ILSON, NC 27893		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 725	Continued From page	9	F	725	 quality of care and to ensure sufficient nursing staffing. Cross refer F686: The Director of Nursand/or licensed nurse supervisor will complete an audit of five (5) residents pressure wounds for documentation p the TAR of treatments as ordered by t physician. Monitoring will be complete a frequency of five (5) times weekly for two (2) weeks, then 3 times weekly for four (4) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QA meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with treatment and services to prevent and heal pressure wounds and to ensure sufficient nursing staffing. 4) The Administrator or DON will more schedule and applicant flow to assure there is adequate staffing Monitoring be completed at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrate will report findings of the monitoring to Interdisciplinary Team (IDT) during QA meetings monthly for three (3) months and will make changes to the plan as necessary thereafter. The Administrate will report findings of the monitoring to Interdisciplinary Team (IDT) during QA meetings monthly for three (3) months and will make changes to the plan as necessary thereafter. The Administrate will report findings of the monitoring to Interdisciplinary Team (IDT) during QA meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance witt RN requirements 8 consecutive hours days a week. 5. Date of Compliance 12/3/2021 	sing with er he d at r or tt API or vnitor will) or the API s an	
	7(02-99) Previous Versions Obs	olete Event ID: KO9	011	Eag	cility ID: 922960	uction choos	Page 10 of 18

Event ID: KO9O11

Facility ID: 922960

If continuation sheet Page 10 of 18

	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345063	B. WING		C 11/04/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
	US HEALTH AT WILSON		1	804 FOREST HILLS ROAD W	
ACCORDI			۱	WILSON, NC 27893	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
F 727	Continued From page	e 10	F 727		
F 727 SS=D	RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1)		F 727		12/3/21
	must use the services				
		f this section, the facility istered nurse to serve as the			
	as a charge nurse on average daily occupa	rector of nursing may serve Ily when the facility has an Incy of 60 or fewer residents. T is not met as evidenced			
	facility failed to sched for at least 8 consecu	iew and staff interview the Jule a registered nurse (RN) Itive hours a day for 3 of the		F727 RN 8 Hours /7days /Wk.1) Corrective action not applicable f	
		12/21, 9/18/21, and 9/19/21).		retroactive dates cited for 9/12, 9/18 a 9/19/21.	and
		d daily staffing sheets from		2) On 11/22/21, the DON, Schedule BOM completed an audit of RN cover	rage
	every day.	21 revealed 1 RN on duty		for previous 30 days to validate accur of 8 consecutive hours of RN coverage daily. Requirements met.	
	-	reviewed on 11/2/21 and o RN scheduled on 9/12/21,		 On 11/22/21, the Administrator educated the Scheduler and ABOM or responsibilities and process of sched and verifying 8 consecutive hours of 	uling
	The census on 9/12/2 9/18/21 and 9/19/21	21 was 55 and the census on was 56.		coverage daily and reporting any discrepancy immediately to the DON and/or Administrator for intervention.	
	The scheduler was in	terviewed on 11/2/21 at 2:30		Scheduler will complete nursing sche	

Event ID: KO9O11

Facility ID: 922960

If continuation sheet Page 11 of 18

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 12/02/202 DRM APPROVE NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345063	B. WING			C 11/04/2021
NAME OF PR	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
4000DD				1804 FOREST HILLS ROAD W		
ACCORDI	US HEALTH AT WILSON			WILSON, NC 27893		
(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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 727	Continued From page	e 11	F 7	27		
	Director of Nursing w coverage. She stated On 11/2/21 at 4:45 ar with the assistant bus she stated she keeps worked. She stated r 9/12/21, 9/18/21, and An attempt to reach t Nursing (DON) for an unsuccessful. An interview was con AM with the interim D speak for the prior ad	he former Director of n interview was nducted on 11/4/21 at 11:35 DON and stated he could not Iministration but going an RN in the building 8 hours		 4 weeks in advance and er consecutive RN hours daily any discrepancies in the RI requirement to the Administ DON for intervention. The I validate actual RN hours we previous day per the electronary transformer as a back-up for validation of coverage in the the scheduler or BOM. The will verify daily schedule in Meeting to ensure RN cover are met. Newly hired Scheer BOMs will receive education 4) The Administrator or D nursing schedule and electronary for the frequency of five (5) times (4) weeks, then weekly for and as necessary thereafted Administrator will report find monitoring to the Interdiscip (IDT) during QAPI meeting three (3) months and will m to the plan as necessary to compliance with RN require consecutive hours, 7 days 5) Date of Compliance 12/3/2021 	y and report N staffing trator and/or BOM will orked for the onic Hosted Administrator scheduling and e absence of Administrator Morning erage needs dulers and on upon hire. ON will monitor ronic Hosted age 8 r requirements. ed at a weekly for four eight (8) weeks er. The dings of the polinary Team s monthly for nake changes maintain ements 8	
F 732 SS=B	Posted Nurse Staffing CFR(s): 483.35(g)(1)	-	F7	32		12/3/21
		affing Information. equirements. The facility ng information on a daily				

If continuation sheet Page 12 of 18

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/02/2021 1 APPROVED). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345063		B. WING			C 11/04/2021			
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT WILSON				304 FOREST HILLS ROAD W			
			WILSON, NC 27893					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 732	Continued From page basis: (i) Facility name. (ii) The current date. (iii) The total number is by the following categ unlicensed nursing sta resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must post (ii) Data must be post (A) Clear and readabl (B) In a prominent pla residents and visitors. §483.35(g)(3) Public a staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requ is greater. This REQUIREMENT by: Based on record revi	and the actual hours worked pories of licensed and aff directly responsible for the second second second second defined under State law). des. In unses or licensed defined under State law). des. In requirements. Set the nurse staffing data in (g)(1) of this section on a inning of each shift. ed as follows: the format. the readily accessible to the second second second second second entry second second second second second second entry second second second second second second second second second second second second second second second second second		732				
	-) days reviewed for staffing			1) Corrective action not applicable for retroactive dates cited for 9/12, 9/18 and			

Facility ID: 922960

If continuation sheet Page 13 of 18

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 11/04/2021	
		345063	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILSON			1804 FOREST HILLS ROAD W WILSON, NC 27893		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 732	 9/1/21 through 9/30/2 duty every day. A review of the daily st through 9/30/21 was not revealed there was not 9/18/21, and 9/19/21. The census on 9/12/2 9/18/21 and 9/19/21 w The scheduler was im PM and she stated sh Director of Nursing wh coverage. She stated of 0n 11/2/21 at 4:45 and with the assistant bus she stated she keeps worked. She stated m 9/12/21, 9/18/21, and An attempt to reach th Nursing (DON) for an unsuccessful. 	the said he would handle it. Interview was conducted interview was conducted interview was son the staff interview was son the s	F 73	 9/19/21. 9/19/21. 2) On 11/22/21, the DON, Scheduler BOM completed an audit of posted nu staffing for previous 30 days to validat accuracy. Requirements met. 3) On 11/22/21, the Administrator provided education to the scheduler and department heads as back-up Manager-on-Duty on the process for posting accurate nurse staffing hours of and updating posting with changes as appropriate per requirements. The Scheduler will be responsible for postin daily staffing Mon-Friday and the Man- on Duty will be responsible for Saturda and Sunday. Newly hired schedulers of Managers on Duty will receive educati upon hire. 4) The Administrator or DON will mo posted nurse staffing for accuracy per requirements. Monitoring will be completed at a frequency of five (5) tin weekly for four (4) weeks, then weekly eight (8) weeks and as necessary thereafter. The Administrator will repor findings of the monitoring to the Interdisciplinary Team (IDT) during QA meetings monthly for three (3) months and will make changes to the plan as 	rse e nd daily daily ng ager ay or on nitor nes for t	
	AM with the interim D speak for the prior ad forward there will be a	ON and stated he could not ministration but going an RN scheduled daily.		necessary to maintain compliance with posted nurse staffing guidelines. 5) Date of Compliance 12/3/21	ו	
F 842 SS=D	Resident Records - Id CFR(s): 483.20(f)(5),		F 84			12/3/21

Facility ID: 922960

If continuation sheet Page 14 of 18

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED		
345063		B. WING			C 11/04/2021				
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-			
					1804 FOREST HILLS ROAD W				
ACCORDI	ACCORDIUS HEALTH AT WILSON			WILSON, NC 27893					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 842	§483.20(f)(5) Resider (i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a col agrees not to use or co except to the extent th to do so. §483.70(i) Medical rea §483.70(i) (1) In accor professional standard must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The faci all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research purp medical examiners, fu a serious threat to hea	nt-identifiable information. elease information that is to the public. lease information that is to an agent only in intract under which the agent disclose the information the facility itself is permitted cords. dance with accepted is and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential ned in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings,	F	842	2				

Facility ID: 922960

If continuation sheet Page 15 of 18

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	12/02/2021 APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED			
		345063	B. WING			(11/0	C 04/2021
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH AT WILSON				1804 FOREST HILLS ROAD W			
				V	VILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	3 15	F	842			
	,.,	ility must safeguard medical ainst loss, destruction, or					
	for-	records must be retained					
	(ii) Five years from the there is no requireme	ars after a resident reaches					
	(i) Sufficient information(ii) A record of the res(iii) The comprehensiveprovided;	ve plan of care and services v preadmission screening					
	determinations condu (v) Physician's, nurse	icted by the State; 's, and other licensed					
	services reports as re	ogy and other diagnostic equired under §483.50.					
	interview the facility fa	ew, staff, and resident ailed to maintain accurate tion Records (TAR) for 1 of			F842 Resident Records Identifiable Information		
	2 residents (Resident care.	#8) reviewed for wound			1) DON to provide education to Nurs on completing electronic documentatio resident treatments on the Treatment		
	The findings included Resident #8 was adm 10/10/20. His diagno	itted to the facility on sis included stage 4			Administration Record (TAR) in PCC eTAR. Late entries were documented f Resident #8 for 9/23, 9/24 and 9/27/21 reflect an accurate, complete medical		
	pressure ulcers and o	steomyelitis.			record for treatments provided. 2) On 11/22/21, the Regional Directo	r of	

Event ID: KO9O11

Facility ID: 922960

If continuation sheet Page 16 of 18

		MEDICAID SERVICES					NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				
	345063		B. WING		C 11/04/2021		
		040000			REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/04/2021
NAME OF PROVIDER OR SUPPLIER				1804 FOREST HILLS ROAD W			
ACCORDIUS HEALTH AT WILSON					LSON, NC 27893		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 842	Continued From page	. 16	F 84	10			
1 042			F 04	+2	Clinical Convisoo (DDCC) completed		
		Data Set (MDS) dated ident #8 was cognitively			Clinical Services (RDCS) completed a audit of the Treatment Administration	a()	
		upervision for transfers and			Records (TAR) from 11/06-11/22/21 for	٦r	
	toilet use and was inc			residents with current wound treatme			
	and eating. The MDS			orders for completion of treatments as			
	pressure ulcers.			ordered. No adverse outcomes to oth			
					residents identified.		
	Resident #8 ' s care p			3) Beginning 11/22-12/2/21, the DO			
		tted with multiple pressure			provided education to current facility a		
		for development of further			agency licensed nurses on document	-	
	pressure ulcers.				treatments completed in PCC eTAR to	C	
	A review of the physic	cian orders for Resident #8			accurately reflect resident medical records. The licensed nurse will docu	mont	
	revealed the following			completion of resident treatments per			
		joiders.			physician orders in PCC eTAR. PCC		
	a. Order dated 5/21/2	21 cleanse right posterior			eTAR education will be provided upor	n hire	
		inser, apply collagen (aids in			and quick reference guides available		
	wound healing) woun			the nursing stations. Newly hired facil			
	cover with a debriding			and agency licensed nurses will recei	ve		
	•	nd secure with tape every			education upon hire.		
	day shift. Order was o	discontinued 10/4/21.			4) The Director of Nursing and/or		
					licensed nurse supervisor will comple		
		21 cleanse sacrum with			audit of five (5) residents with wounds	6	
		y a debriding agent to			treatment orders for accurate	20	
		ld bed, cover with another dressing, thick absorbent			documentation per the TAR. Monitorin will be completed at a frequency of fiv	-	
		with tape every day shift.			times weekly for four (4) weeks, then	e (3)	
	Order was discontinu				weekly for eight (8) weeks and as		
					necessary thereafter. The Administration	tor	
	c. Order dated 5/21/2	21 cleanse left ischium with			will report findings of the monitoring to		
		/ a debriding agent, cover			Interdisciplinary Team (IDT) during Q	API	
		k absorbent dressing and			meetings monthly for three (3) months		
	secure with tape ever	y day shift.			and will make changes to the plan as		
					necessary to maintain compliance	4	
		1 cleanse right calf with			maintaining accurate, complete reside	ent	
		y collage wound powder to			medical records.5) Date of Compliance 12/3/2021		
		h debriding agent, dry pent dressing, rolled gauze					
	and secure with tape						

Facility ID: 922960

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
345063		B. WING _			C 11/04/2021		
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT WILSON				804 FOREST HILLS ROAD W VILSON, NC 27893		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From page	e 17	F	842			
	e. Order dated 7/30/21 cleanse right ischium with wound cleanser, apply a debriding agent, ABD pad and secure with tape every day shift.						
		1 apply a topical antibiotic to ry day shift for wound care. ed 10/4/21					
		revealed these dressing cumented as completed on					
	PM. He stated he co	rviewed on 11/3/21 at 2:30 ouldn ' t recall 9/23/21, it if they were during the were probably done.					
	She stated she worke 9/27/21 and was resp dressing change. Sh dressing on those dat document dressing cl #2 stated she had be	tes but was not educated to hanges in the TAR. Nurse					
	Director of Nursing or stated he expected st when treatment was	ducted with the interim n 11/4/21 at 11:35 AM. He taff to sign off on the TAR completed and if they are ocument dressing changes ompleted.					

Facility ID: 922960

If continuation sheet Page 18 of 18