DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES						M APPROVE
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u> </u>	MB NO	D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(	COM	SURVEY PLETED
		345236	B. WING					C / <b>19/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		11/	15/2021
400000		a ton		8	20 WELLINGTON AVENUE			
ACCORDI	US HEALTH AT WILMIN	GIUN		V	VILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	E	(X5) COMPLETION DATE
E 030 SS=F	-		E	030				12/17/21
	§441.184(c)(1), §460 §483.73(c)(1), §483.4 §485.68(c)(1), §485.4	5.54(c)(1), §418.113(c)(1), 0.84(c)(1), §482.15(c)(1), 475(c)(1), §484.102(c)(1), 625(c)(1), §485.727(c)(1), 5.360(c)(1), §491.12(c)(1),						
	emergency prepared that complies with Fe and must be reviewe 2 years [annually for	develop and maintain an ness communication plan ederal, State and local laws d and updated at least every LTC facilities]. The must include all of the						
	following: (i) Staff.	nct information for the services under arrangement. Ins						
	§485.625(c)] The cor include all of the follo (1) Names and conta following: (i) Staff.	ict information for the						
	<ul> <li>(ii) Entities providing</li> <li>(iii) Patients' physicia</li> <li>(iv) Other [hospitals a</li> <li>(v) Volunteers.</li> </ul>							
	*[For RNHCIs at §40 communication plan following:	3.748(c):] The must include all of the						
30RATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE			(X6) DATE
Electroni	cally Signed							12/15/202

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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				FORI	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345236	B. WING			11	/19/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT WILMING	GTON			820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 030	<ul> <li>(1) Names and contact following:</li> <li>(ii) Staff.</li> <li>(iii) Entities providing staff.</li> <li>(iii) Next of kin, guard</li> <li>(iv) Other RNHCIs.</li> <li>(v) Volunteers.</li> <li>*[For ASCs at §416.4 plan must include all of (1) Names and contact following:</li> <li>(i) Staff.</li> <li>(ii) Entities providing staff.</li> <li>(iii) Patients' physician (iv) Volunteers.</li> <li>*[For Hospices at §41 communication plan r following:</li> <li>(1) Names and contact following:</li> <li>(1) Patients' physician (iv) Other hospices.</li> <li>*[For HHAs at §484.1 plan must include all of (1) Names and contact following:</li> <li>(ii) Entities providing staff.</li> <li>(ii) Patients' physician (iv) Volunteers.</li> </ul>	ct information for the services under arrangement. ian, or custodian. 5(c):] The communication of the following: ct information for the services under arrangement. ns. 18.113(c):] The must include all of the ct information for the s. services under arrangement. ns. 02(c):] The communication of the following: ct information for the services under arrangement. ns.	E	030			

Facility ID: 923408

If continuation sheet Page 2 of 25

	-	D HUMAN SERVICES				FORM	1 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING			( 11/ <sup>,</sup>	C 19/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				82	20 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMING	SION		W	/ILMINGTON, NC 28401		
(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
E 030	<ul> <li>(2) Names and contact following:</li> <li>(i) Staff.</li> <li>(ii) Entities providing states (iii) Volunteers.</li> <li>(iv) Other OPOs.</li> <li>(v) Transplant and do Donation Service Areat This REQUIREMENT by:</li> <li>Based on record revifacility failed to include information for staff, rother long term care for preparedness commuters.</li> <li>Findings included:</li> <li>A review of the facility plan in section E00300 information for the contact information physicians, and other not included.</li> <li>An interview was comated to include the plan di contact information for stated to physicians, and other not included.</li> </ul>	ct information for the services under arrangement. nor hospitals in the OPO's a (DSA). is not met as evidenced ew and staff interview, the e the names and contact esidents' physicians, and acilities in the emergency unication plan. 's emergency preparedness for names and contact mmunication plan revealed n for staff, residents' long term care facilities was ducted with the facility 8/21 at 9:30 AM. The he Emergency d not include the names and r employees, residents' long term care facilities . n should have included this nd stated the information	E	030	The Plan of correction is not to be construed as an admission of any wror doing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, for appeal proceedings or any administration or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction sho be considered as a waiver of any potentially applicable Peer Review, Quassurance or self-critical examination privilege which the facility does not wat and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers response, credible allegations of compliance and plan of correction as p of its ongoing efforts to provide quality care to residents E030 Names and Contact Information	ne mal ve nts uld ality ve its art	

Facility ID: 923408

If continuation sheet Page 3 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/22/202 <sup>·</sup> M APPROVEI D. 0938-039 <sup>·</sup>
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` <i>`</i>		CONSTRUCTION	COMF	E SURVEY PLETED	
		345236	B. WING			C 11/19/2021	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH AT WILMINGTON					20 WELLINGTON AVENUE VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 030 E 031 SS=F	CFR(s): 483.73(c)(2) §403.748(c)(2), §416 §441.184(c)(2), §460 §483.73(c)(2), §483.4 §485.68(c)(2), §485.6 §485.920(c)(2), §485.6 §494.62(c)(2). [(c) The [facility] must emergency prepared that complies with Fe and must be reviewed 2 years [annually for communication plan r following: (2) Contact information (i) Federal, State, trib emergency prepared (ii) Other sources of a	Contact Information .54(c)(2), $§418.113(c)(2)$ , .84(c)(2), $§482.15(c)(2)$ , .75(c)(2), $§484.102(c)(2)$ , .525(c)(2), $§485.727(c)(2)$ , .360(c)(2), $§491.12(c)(2)$ , t develop and maintain an ness communication plan deral, State and local laws d and updated at least every LTC facilities]. The must include all of the on for the following: al, regional, and local ness staff. assistance. t §483.73(c):] (2) Contact		030	<ol> <li>The facilities Emergency Preparedness plan in section E0030 for names and contact information for the communication plan revealed contact information for staff, residents □</li> <li>physicians and other Long term Care facilities was not included.</li> <li>Information was added to the plan</li> <li>Administrator was educated on the need to fulfill requirements of the Emergency Preparedness Plan</li> <li>Emergency Preparedness plan wi reviewed monthly for accuracy by NHA</li> </ol>	e	12/17/21

Facility ID: 923408

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/22/2021 APPROVED . 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE S COMPL	ETED	
		345236	B. WING			11/19/2021		
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
ACCORD	IUS HEALTH AT WILMING	GTON			20 WELLINGTON AVENUE			
				v				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 031	Continued From page	e 4	E	031				
		al, regional, and local	_					
	emergency prepared							
		ng and Certification Agency. State Long-Term Care						
	Ombudsman.	State Long-Term Care						
	(iv) Other sources of	assistance.						
	*[For ICF/IIDs at §483	3.475(c):] (2) Contact						
	information for the fol	lowing:						
	(i) Federal, State, trib emergency prepared	al, regional, and local						
	(ii) Other sources of a							
	(iii) The State Licensi	ng and Certification Agency.						
		tion and Advocacy Agency.						
	by:	is not met as evidenced						
		iew and staff interviews, the			E031 Emergency Plan			
		le contact information for						
		ncies including the State cation Agency and the Office			<ol> <li>The facilities Emergency preparedness plan did not include con</li> </ol>	tact		
		m Care Ombudsman in the			information for federal and state agend			
	emergency plan.				including the State Licensing and			
	Findings included:				Certification Agency and the Office of State Long-Term Care Ombudsman. 1			
					plan only included contact information			
	-	's emergency preparedness			the county Emergency Management			
	-	for emergency officials			system.			
		evealed the plan did not nation for federal and state			2) Information was added to the Emergency Preparedness Plan			
		e State Licensing and			3) Administrator was educated on th	e		
		and the Office of the State			need to fulfill requirements of the			
		oudsman. The plan only mation for the county			Emergency Preparedness Plan 4) Emergency Preparedness plan w	ill be		
	Emergency Managen	-			reviewed monthly for accuracy by NH/			
	An interview was con	ducted with the facility						
		8/21 at 9:30 AM. He stated						
		e contact information for the						
	Judie Licensing and C	Certification Agency and the						

If continuation sheet Page 5 of 25

TATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		MB NO. 0938 X3) DATE SURVE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		COMPLETED	
		345236	B. WING			C 11/19/202	21
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILMIN	GTON		82	20 WELLINGTON AVENUE		
ACCORDI		STON		W	ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMP	X5) PLETION ATE
E 031	Continued From page	e 5	Í F	031			
		ng-Term Care Ombudsman					
		d in the plan. He concluded					
		included this contact					
		d the information would be					
	added to the plan.						
F 000	INITIAL COMMENTS	5	F	000			
	A recertification surv	ev and complaint					
		iducted onsite 11/15/21 -					
	-	ly through 11/19/21. Event ID					
	# NVUJ11.	, ,					
	1 of 1 complaint alleg	ation was not subsantiated.					
F 641	Accuracy of Assessm	nents	F	641		12/17	'/21
SS=D	CFR(s): 483.20(g)						
	§483.20(g) Accuracy	of Assessments.					
		st accurately reflect the					
	resident's status.						
		「 is not met as evidenced					
	by: Based on observatio	ns, record review and staff			The Plan of correction is not to be		
		failed to accurately code an			construed as an admission of any wrong		
	MDS (Minimum Data	-			doing or liability. The facility reserves the		
		g whose MDS assessment			rights to contest the survey findings		
		ive assist for eating and			through informal dispute resolution, form		
		dent resident (Resident #57)			appeal proceedings or any administrativ	e	
	and failed to accurate				or legal proceedings. This plan of		
	-	e of motion (Resident #15) whose MDS assessment			correction is not meant to establish any		
	were reviewed.	WI1036 WIDO assessillell			standard of care, contract obligation or position and the facility reserves all right	s	
	noro roviowou.				to raise all possible contentions and	-	
	Findings included:				defenses in any type of civil or criminal		
		admitted to the feelite an			claim, action or proceeding. Nothing	d	
	-	admitted to the facility on ses that included diffuse			contained in this plan of correction shoul be considered as a waiver of any	u	
		with loss of consciousness			potentially applicable Peer Review, Qua	lity	

Facility ID: 923408

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/22/2021 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		E SURVEY IPLETED
		345236	B. WING _		1'	C 1/19/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
				820 WELLINGTON AVENUE		
ACCORD	US HEALTH AT WILMING	GIUN		WILMINGTON, NC 28401		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 641	up truck or van in nor injury, and dysphagia Review of an annual 10/24/21 documented impaired cognition. H bowel and bladder. H tracheostomy. He ha and lower extremities assessment documen assistance from staff toilet use. He was de locomotion, dressing, bathing. In an interview with th 11/18/21 at 9:30 AM I information contained be accurate. In an interview on 11/ Nurse #8, MDS, he s able to assist with ea dependent for both A assessment was cod documenting the resi assistance. He state- transmitted to correct	ant side, paraplegia, ured in collision with car/pick n-traffic accident, intracranial n. MDS assessment dated d Resident #57 had severely le was always incontinent of de had a feeding tube and a ad an impaiment of his upper s on both sides. The need he required extensive for bed mobility, eating and ependent for transfers, personal hygiene and the stated he expected the d in the MDS assessments to (18/21 at 12:05 PM with tated Resident #57 was not ting or toilet use and was DL's. He concluded the ed inaccurately by dent had required extensive d a modification would be the assessment that was 21 to reflect Resident #57	F 6		bes not waive sert in any nal claim, acility offers its ns of ection as part ide quality of ents dification ARD 10/24/21 g and toilet bodification 0 9/16/21 to mity tents have ted. ned that all to be affected or Activities of e MDS udit of current nd splint use ating and . Modifications re been s appropriate a program was eimbursement inator(s) of identifying htractures with MDS ADL	

Event ID: NVUJ11

Facility ID: 923408

If continuation sheet Page 7 of 25

IND PLAN OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING     COMPLET       A. BUILDING     B. WING     C       345236     B. WING     11/19/2       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ACCORDIUS HEALTH AT WILMINGTON     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID			X MEDICAID SERVICES	(X2) MI II TIOI	E CONSTRUCTION		0. 0938-03
346236         B. WING         111197           ACCORDUS HEALTH AT WILMINGTON         STREET ADDRESS, CITY, STATE, ZIP CODE         20         STREET ADDRESS, CITY, STATE, ZIP CODE         20         CILINGTON, NC 28401         0         0           (44,10)         SUMMAY STATEMENT OF GERGENCIES         DP         PROVIDERS FLAW NOT CONFECTION         0         PREVEX         CROSS-REFERENCES TO THE APPROPRIATE         0           F641         Continued From page 7         2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, being prostate hypertorphy (enlarged prostate) and unstageable pressure ulcers.         F641         Activities of Daily Living. Newly hired MDS Coordinators will receive education during orientation.         0           An observation of Resident #15 on 11/15/21 revealed free resident was severely contracted to his bilateral lower extremities.         F641         Activities of three (3) neither MIDS audition prof findings of the monitoring to the Interdisciplicany Team (DT) during QAPI meetings and their MDS/medical records will be reviewed to ensure that ADLs and ROM ability are identified and accurately coded on MDS assessement. The Administrator will report findings of the monitoring to the Interdisciplicany Team (DT) during QAPI meetings and advert existent whe hourd conduct a visual assessment. The Administrator will report findings of the monitoring to the Interdisciplicany Team (DT) during QAPI meeting with Nurse #8 stated ho was not aware Resident #15 had bilateral lower existent scannels on the resident will be reviewed to sing staff and he would conduct a visual assessement.         An interview with the Admi				· · ·		СОМ	PLETED
ACCORDUS HEALTH AT WILMINGTON         B20 WELLINGTON AVENUE WILMINGTON, NC 22001           COULD PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCES (EXCURPTION OF USE (DENTIFYING INFORMATION))         PREFIX (EXCURPTION OF USE (DENTIFYING INFOR			345236	B. WING			C / <b>19/2021</b>
CACCORDUST HEALTH AT WILMINGTON       WILMINGTON, NC 28401         (M) D TRG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCE DEB STALL FECULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDENTIFYING INFORMATION	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WILMINGTON, NC 20401           PROVIDER'S FLATORY OR LSC IDENTIFYING INFORMATION)         Imperiation           F 641         Continued From page 7           2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers.         F 641           The quarterly MDS assessment dated 09/16/21 revealed Resident #15 was severely cognitively impaired and had no impairments.         F 641           An observation of Resident #15 on 11/15/21 revealed the resident was severely cognitively impaired and had no impairments.         F 641           An interview with Nurse #1 on 11/17/21 at 10.35         Af interview with Nurse #1 on 11/17/21 at 10.35         F 641           An interview with Nurse #8 stated when he needed to complete an assessment he would review the physician orders, progress notes, and theray orders, would interview the mursing staff and he would conduct a visual assessment.         Result and some the solution or 11/18/21 at 4.17 PM revealed the esident #15 had bilateral contractures and he should have coded him with bilateral lower extermily impairments on his quarterly assessment.         An interview with the Administrator on 11/18/21 at 4.17 PM revealed the espected the MDS nurses	ACCORDI	US HEALTH AT WILMI	NGTON		820 WELLINGTON AVENUE		
IdeAl DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRETX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSSREPERENCEDED TO THE APROPRIATE DEFICIENCY)         F 641       Continued From page 7       F 641         2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers.       F 641         The quarterly MDS assessment dated 09/16/21 revealed Resident #15 was severely cognitively impaired and had no impairments.       F 641         An observation of Resident #15 on 11/15/21 revealed the resident was severely cognitively impaired and had no impairments.       F 011/15/21 revealed the resident was severely contracted to his bilateral lower extremities. The resident was noted to be wearing off loading boots to bilateral extremities.       F 011/17/21 at 10:35 AM revealed the resident was severely contracted to his bilateral lower extremities. The resident was noted to be wearing off loading boots to bilateral extremities.       F 011/17/21 at 10:35 AM revealed the resident was severely compared to ward will make changes to the plan as necessary to maintain compliance with MDS coding accuracy.         An interview with Nurse #1 on 11/17/21 at 10:05 Nurse on 11/18/21 at 3:00 PM. Nurse #8 stated when he needed to complete an assessment he would review the physician orders, progress notes, and therapy orders, would interview the nursing staff and he would conduct a visual assessment.       An interview with the Administrator on 11/18/21 at 4:17 PM revealed he expected the MDS nurses to update the assessment.	AUGUNDI				WILMINGTON, NC 28401		
<ul> <li>2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers.</li> <li>The quarterly MDS assessment dated 09/16/21 revealed Resident #15 was severely cognitively impaired and had no impairments.</li> <li>An observation of Resident #15 on 11/15/21 revealed the resident was severely contracted to his bilateral lower extremities.</li> <li>An interview with Nurse #1 on 11/17/21 at 10:35 AM revealed the resident has had bilateral lower extremity contractions for at least 6 months or more and could not ambulate.</li> <li>An interview was conducted with Nurse #8 (MDS Nurse) on 11/18/21 at 3:00 PM. Nurse #8 stated he would review the physician orders, progress notes, and therayo orders, would interview the nursing staff and he would conduct a visual assessment.</li> <li>An interview with the Administrator on 11/18/21 at 4:17 PM revealed the expected the MDS nurses to update the assessment.</li> </ul>	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETIC DATE
<ul> <li>2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers.</li> <li>The quarterly MDS assessment dated 09/16/21 revealed Resident #15 was severely cognitively impaired and had no impairments.</li> <li>An observation of Resident #15 on 11/15/21 revealed the resident was severely contracted to his bilateral lower extremities.</li> <li>An interview with Nurse #1 on 11/17/21 at 10:35 AM revealed the resident has had bilateral lower extremity contractions for at least 6 months or more and could not ambulate.</li> <li>An interview was conducted with Nurse #8 (MDS Nurse) on 11/18/21 at 3:00 PM. Nurse #8 stated when he needed to complete an assessment he would review the physician orders, progress notes, and therapy orders, would interview the nursing staff and he would conduct a visual assessment.</li> <li>An interview with the Administrator on 11/18/21 at 4:17 PM revealed the exsessment.</li> <li>An interview with the Administrator on 11/18/21 at 4:17 PM revealed the essessment.</li> </ul>	F 641	Continued From page	de 7	F 64			
An interview with the Administrator on 11/18/21 at 4:17 PM revealed he expected the MDS nurses to update the assessment to accurately reflect the		07/02/18. Diagnose prostate hypertroph unstageable pressu The quarterly MDS revealed Resident # impaired and had no An observation of R revealed the resider his bilateral lower ex noted to be wearing extremities. An interview with No AM revealed the resider extremity contraction more and could not An interview was co Nurse) on 11/18/21 when he needed to would review the ph notes, and therapy of nursing staff and he assessment on the was not aware Resident contractures and here bilateral lower extremited and the assessed to the there and the bilateral lower extremited assessment on the there and th	es included, in part, benign y (enlarged prostate) and re ulcers. assessment dated 09/16/21 415 was severely cognitively o impairments. esident #15 on 11/15/21 ht was severely contracted to ktremities. The resident was off loading boots to bilateral urse #1 on 11/17/21 at 10:35 sident has had bilateral lower ns for at least 6 months or ambulate. unducted with Nurse #8 (MDS at 3:00 PM. Nurse #8 stated complete an assessment he sysician orders, progress orders, would interview the would conduct a visual resident. Nurse #8 stated he dent #15 had bilateral should have coded him with mity impairments on his		<ul> <li>Coordinators will receive education.</li> <li>4) The Director of Nursing Service designee, will conduct a random three (3) residents MDS submissions week x four (4) weeks then mont (2) months. These residents and MDS/medical records will be revicensure that ADLs and ROM abilities identified and accurately coded of assessment. The Administrator will findings of the monitoring to the Interdisciplinary Team (IDT) during meetings monthly for three (3) meand will make changes to the planecessary to maintain compliance.</li> </ul>	on during vices, or audit of ions per hly x two I their ewed to y are y are y are vill report on MDS vill report on ths n as	
F 684 Quality of Care F 684 12	F 684	An interview with th 4:17 PM revealed h to update the asses residents ' current of	e Administrator on 11/18/21 at e expected the MDS nurses sment to accurately reflect the	F 684	4		12/17/21

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/22/2021 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345236	B. WING _				C 19/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	TATE, ZIP CODE	
			820 WELLINGTON AVENUE		0 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMING	STON	WILMINGTON, NC 28401		ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	8	F	684			
	applies to all treatment facility residents. Basis assessment of a resident that residents receive accordance with profe- practice, the comprehe care plan, and the resident This REQUIREMENT by: Based on record revi- physician assistant (F failed to follow the phy- blood sugars and adminesident reviewed for (Resident #85). Findings included: Resident #85 was add 1/29/19 with diagnose Diabetes Mellitus (DMinesident #85) blood pressure). Resident the hospital from 10/2 (low blood sugar). The Resident #85 on 10/5 The quarterly Minimuli indicated Resident #8 cognitively impaired. A review of Resident and DM. The interventions diabetes medications	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices. T is not met as evidenced ew, staff, physician and PA) interviews, the facility ysicians' orders to obtain ninister insulin for 1 of 1 insulin administration mitted to the facility on es which included Type I 1) and hypertension (high dent #85 was admitted to P-10/5/21 for hypoglycemia e facility readmitted /21. m Data Set dated 10/7/21			<ul> <li>F684 Quality of Care</li> <li>1) Resident #85 continued to receiver insulin until discharged from the facility 10/8/21.</li> <li>2) Residents with insulin orders were audited by the DON on 11/18/21. No additional concerns identified.</li> <li>3) DON/Designee provided education facility and agency licensed nurses on following physician orders and documentation of medication administration. The licensed nurse will administer insulin as ordered by the physician and document accordingly of the Medication Administration Record (MAR). Newly hired facility and agency licensed nurses will receive education during orientation.</li> <li>4) The Director of Nursing and/or licensed nurse supervisor will complete audit of five (5) residents with insulin orders for documentation per the MAR administration as ordered by the physician. Monitoring will be completed a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8)</li> </ul>	on to n of dat	

Event ID: NVUJ11

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/22/2021 MAPPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		345236	B. WING			C 11/19/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	US HEALTH AT WILMIN	GTON		82	20 WELLINGTON AVENUE			
ACCORDI	US REALTH AT WILWIN	GIÓN		N	VILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	Continued From page		F	684				
	insulin) per sliding sc 0-200= 0 units, 201-2 units, 301-350=6 unit subcutaneously (inject between the skin and at bedtime for DM. " Administer 3 unit acting) after meals fo or blood sugar <200 " Administer Touje insulin) one time a da Review of Resident # Administration Recor revealed her blood su low of 34 to a high of 10/8/21 revealed Not documented for the E Medication Aide (CM documented for the s by CMA #3 at 7:30 A revealed a 9 meant s MAR note document revealed the SS insu review of Resident #8 short-acting insulin p meals at 7:00 PM (ho sugar <200) was blar	o insulin pen ( a fast-acting ale (SS): If blood sugar (BS) 250= 2 units, 251-300= 4 ts, 351-400=8 units. ction into the fat layer d muscle) before meals and ts of Lispro insulin (short or DM. Hold if meal not eaten start date 10/8/21 at 7pm. to insulin pen (long acting ay at 7:30 AM for DM. 485's Medication rd (MAR) for October 2021 ugar results ranged from a 583. Review of the MAR for t Applicable (NA) was 35 at 7:30 AM by Certified			weeks and as necessary thereafter. Administrator will report findings of the monitoring to the Interdisciplinary Tea (IDT) during QAPI meetings monthly three (3) months and will make chang to the plan as necessary to maintain compliance with insulin administration quality of resident care.	e im for ges		
	A telephone interview 10:39 AM with CMA check the residents' I	v conducted on 11/17/21 at #3 revealed her job was to blood sugars before them to the nurse. She						
	stated CMAs could n	ot administer insulin. CMA						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING				C 19/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMING	GTON			20 WELLINGTON AVENUE VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	she was behind on he had asked Nurse #3 t Resident #85 at 7:30 #3 had not obtained t administered the slidii #85 on 10/8/21 at 7:3 that Nurse #3 had ins on Resident #85's MA In a telephone intervie on 11/17/21 at 2:58 P CMAs' responsibility t sugars and report the was the nurses' responsibility f sugars and report the not obtained the blood AM. Nurse #3 revealed CMA #3 to get Reside 10/8/21. Nurse #3 revealed CMA #3 to get Reside 10/8/21 at 7:00 PM be responsibility to admin revealed she had rep units of fast-acting ins She further revealed a had obtained a blood insulin. 11/19/21 Attempted to	at on the morning of 10/8/21 er medication pass and she to obtain the blood sugar for AM. She stated that Nurse he blood sugar or ng scale insulin for Resident 0 AM. She further stated structed her to document NA AR. ew conducted with Nurse #3 M she revealed it was the to obtain the residents' blood em to the nurse. She stated it onsibility to administer the e further stated that if the ulin was not signed off on or Resident #85 then she further revealed she had d sugar on 10/8/21 at 7:30 ed she was not asked by ent #85's blood sugar on vealed she had given the 10/8/21 at 7:30 AM. was conducted on 11/19/21 #4. She stated she had not ar for resident #85 on ecause it was Nurse #6's nister the insulin. CMA #4 orted the new order for 3 sulin at 7:00 PM to Nurse #6. she was unsure if Nurse #6 sugar or administered the	F	684			
	An Interview was con	ducted on 11/18/21 at 11:07					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING				C 19/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMING	GTON			20 WELLINGTON AVENUE WILMINGTON, NC 28401		
(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 684 F 690 SS=D	blood sugars and the The PA stated the me Resident #85's blood because her blood su She further stated she blood sugars would h from not getting the 2 insulin on 10/8/21. An interview was com Physician on 11/18/21 interview the Physicia been in the hospital fr diagnosis of hypoglyc stated Resident #85 h diabetic and her blood the place. He reveale 300-400 range was com revealed that he did n of insulin on 10/8/21 a to her demise. An interview was com PM with the Director of stated she didn't know obtained the blood su fast-acting insulin on PM. The DON stated follow the Physicians' correctly on the MAR. Bowel/Bladder Incont	h Assistant (PA). She 5 would have very high in they would drop very low. dical team would allow sugars to run a little high igars would drop so fast. e didn't think Resident #85's ave gone up very much missed doses of fast-acting ducted with Resident #85's 1 at 12:00 PM. During the in stated Resident #85 had rom 10/2/-10/5/21 with the remia (low blood sugar). He had been a very brittle d sugars would be all over d that blood sugars in the formon for her. He further not think the 2 missed doses at 7:30 AM and 7:00 PM led ducted on 11/18/21 at 12:56 of Nursing (DON). The DON why the nurses had not igars or administered the 10/8/21 at 7:30 AM and 7:00 she expected the nurses to orders and to document		684			12/17/21
	§483.25(e) Incontiner §483.25(e)(1) The fac	ice.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING				C 19/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				8	320 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMING	SION		١	WILMINGTON, NC 28401		
(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 690	maintain continence u condition is or becom not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who entri indwelling catheter is resident's clinical con- catheterization was no- (ii) A resident who entri indwelling catheter or is assessed for remov- as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate to prevent urinary tract in continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a resident receives appropriate to restore as much norm possible. This REQUIREMENT by: Based on observation physician assistant in to: 1) clarify and trans- continuous indwelling	ervices and assistance to unless his or her clinical es such that continence is ain. sident with urinary on the resident's sement, the facility must ers the facility without an not catheterized unless the dition demonstrates that eccessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nefections and to restore ent possible. esident with fecal on the resident's sement, the facility must t who is incontinent of bowel treatment and services to nal bowel function as " is not met as evidenced ins, record review, staff and terviews, the facility failed coribe an order for a urinary catheter to include er and orders to maintain	F	690	F690 Bowel/Bladder Incontinence, Catheter 1) On 11/18/21, the licensed nurse obtained clarification orders for Reside #15 catheter to include catheter size,	nt	

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		ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 12/22/202 ORM APPROVEI NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OATE SURVEY
		345236	B. WING _				C 11/19/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				82	20 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMIN	GION		v	VILMINGTON, NC 28401		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 690	Continued From nor	- 12		200			
F 090	Continued From page		FC	690			
		n catheter care and maintain			catheter care and catheter tubing		
		y and privacy for 1 of 2			securement to ensure resident cathe		
		(15), and; 2) failed to position catheter below the level of			care, dignity and privacy are maintain Resident #49 catheter bag continues		
		It back flow of urine for 1 of 2			be positioned below the level of the	5 10	
		49) reviewed for catheter			bladder to prevent backflow of urine.		
	care.				2) DON completed an audit of resid		
					with catheters for completeness and		
	Findings included:				accuracy of physician orders to inclu	de	
					size, securement and care. No addit	ional	
		is admitted to the facility on			concerns identified.		
	-	included, in part, benign			<ol> <li>DON/designee provided educati</li> </ol>		
		(enlarged prostate) and			facility and agency licensed nurses of		
	unstageable pressure	e ulcers.			obtaining and validating catheter ord		
	The Minimum Date S	ot (NDS) datad 00/16/21			are complete and inclusive of size, to securement and catheter care and the	-	
		et (MDS) dated 09/16/21 t revealed resident #15 was			care is provided and documented on		
	severely cognitively in				Treatment Administration Record (TA		
	, , ,	r and frequently incontinent			as ordered. The licensed nurse will		
		der hospice care. Resident			ensure residents with catheters rece	ive	
		ndwelling urinary catheter			appropriate catheter care and that or	rders	
	during this assessme				are complete. Newly hired facility and		
					agency licensed nurses will receive		
		#15 ' s care plan dated			education during orientation.		
		ere was no plan of care for			4) The Director of Nursing and/or		
		catheter. A plan of care was			licensed nurse supervisor will comple		
	in place for incontine	nce.			audit of residents with catheters for c		
	An observation of De	sident #15 on 11/15/21			completeness and TAR documentation ordered by the physician. Monitoring		
		sident #15 on 11/15/21 had an indwelling urinary			be completed at a frequency of five (		
		centrated amber colored			times weekly for four (4) weeks, ther		
	•	noted to be hanging below			weekly for eight (8) weeks and as	•	
		er on the bed rail. The bag			necessary thereafter. The Administra	ator	
		covered with a privacy bag			will report findings of the monitoring		
		ng was not secured with a			Interdisciplinary Team (IDT) during G		
	catheter securing dev				meetings monthly for three (3) month		
	-				and will make changes to the plan as		
		ducted with Nurse Aide (NA)			necessary to maintain compliance w	ith	
	#1 on 11/16/21 at 9:1	0 AM. NA #4 stated she did			care for residents with catheters.		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345236	B. WING				C / <b>19/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
ACCORD	US HEALTH AT WILMING	GTON			820 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 690	not know why the cat secured to the reside know why the dignity NA #1 stated the hos A hand written physical was in the physical cl foley catheter due to wound healing." The size of catheter to be saline to inflate the ba catheter stay in place order was signed by f and Nurse #1. A review of the EMR catheter was entered to have an end date of indicate the size of th the amount of saline f A review of another p dated 10/18/21 stated The order did not indi or the amount of salin The Medication and T Records were review and November. Ther for catheter care. A review of the physic the electronic medicat there were no current insertion of an indwel Additionally, there we for the catheter to inc placement, daily clea	heter tubing was not nt ' s leg and she did not bag was not on the catheter. pice staff took care of it. ian order dated 10/07/21 hart and indicated "place a contractures and promote order did not indicate the inserted or the amount of alloon which helped the within the urinary tract. The the Physician Assistant (PA) revealed the order for the in the EMR but it was noted of 10/08/21 and did not e catheter to be inserted or to fill the balloon. hysician hand written order d "replace foley catheter." cate the size of the catheter he to fill the balloon. Treatment Administration ed for the month of October e were no orders in place cian orders on 11/16/21 in I record (EMR) revealed c orders in place for the ling urinary catheter. re no orders in place to care lude checking catheter for	F	690				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/22/2021 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING _					C 19/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	=		
				82	20 WELLINGTON AVENUE			
ACCORDI	US HEALTH AT WILMING	TON		W	/ILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 690	bag. An interview was com Nurse #2 on 11/17/21 reviewed Resident #1 EMR and stated there for an indwelling urina stated she recalled pu on 10/07/21 to place to that she put an end da discontinue) on 10/08 did not know why she in the EMR because to continued use. Nurse the size of the catheter in the balloon. Nurse the actual order for 10 replace foley catheter progress note she had the foley catheter was French (size of the cat centimeters amount of Nurse #1 and #2 conf no actual orders to ins with 10cc balloon and replace foley catheter stated there should be meant additional order prompted to be select catheter order was pu added the batch order foley catheter placem daily or each shift, cha monthly, provide dign secure catheter tubing confirmed that withou	ducted with Nurse #1 and at 10:40 AM. The nurses 5 's physician orders in the were no orders in the EMR ary catheter. Nurse #1 atting the order in the EMR the foley catheter and noted ate (which meant to /21. Nurse #1 stated she would have put an end date he catheter was for e #1 stated she did not know er or how much saline was #2 stated she could not find 0/18/21 in the EMR to but that she did find a d written on 10/19/21 that changed per orders with 16 theter) 10cc (cubic f saline in the balloon). irmed, however, there were sert a 16 French catheter the order only stated to . Additionally, both nurses e "batch" orders which rs would have been ed if the indwelling urinary t in the EMR. The nurses rs included to check for ent, cleanse the catheter ange the catheter bag ity cover for privacy, and g in place. Both nurses t the order being put in the	F	590	DEFICIENCY)			
	EMR it would not trigg	ger to the MAR as a nursing ere doing care for this						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/22/2021 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING					C 19/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP	CODE		
ACCORD	US HEALTH AT WILMING	STON		8	320 WELLINGTON AVENUE			
ACCORD				۱ ا	WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD B		(X5) COMPLETION DATE
F 690	catheter. The nurses catheter was put into selected the appropria orders would have ap nurses could check of was in place, being cl shift, covered with a c was secured. An interview was con- 11/17/21 at 2:40 PM. that were hand writter and stated the orders size of the catheter to amount. The PA state and 10cc balloon amor resident at this time, t clarified in the physici EMR. 1b. An observation o #15 was conducted o NA #3. NA #3 entered provided privacy, was gloves, raised the resider any soap. She was n cloth and proceeded to starting at the meatus cleansed the tubing w along the tubing. NA wash cloth to clean the	stated if the order for the the system they would have ate care measures and the opeared on the MAR so the ff each shift that the catheter leansed daily or with each dignity bag, and the tubing ducted with the PA on The PA reviewed the orders in on 10/07/21 and 10/18/21 should have indicated the be inserted and the balloon ed the 16 French catheter ount was appropriate for the out it should have been ian order and entered in the f catheter care for Resident in 11/18/21 at 2:15 PM with d the resident ' s room, shed her hands, applied ident ' s bed, lowered the the brief, and proceeded to IA #3 wet the wash cloth in in t ' s room and did not apply noted to use only one wash to clean the catheter tubing a (opening of the penis) and <i>v</i> ith an up and down motion #3 did not use a separate he meatus or a separate he shaft of the penis. The was not secured to the catheter strap.	F	690				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING				C 19/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT WILMING	GTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401				
(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 690	a nurse aide for 3 year usually clean catheter realize she was doing recall the last time sho care. NA #3 stated the to prevent the tubing she would let the nurse secured. An interview was com- Nursing (DON) on 11/ DON stated there sho insert the indwelling of catheter size and the stated she would have clarify the order when The DON stated the cath it was getting cleanse catheter bag was cov- tubing was secured. certain any of these ta or each shift since it r the nurses to sign off completed. The DON education was done u demonstration and ar #3 had been educated should have known he appropriately. 2.) Resident #49 was	A #3 reported she had been ars but that she did not rs. NA #3 stated she did not g it wrong and could not e was educated on catheter e tubing should be secured from kinking. NA #3 stated se know that it was not ducted with the Director of (18/21 at 4:15 PM. The buld have been an order to ratheter to include the balloon amount. The DON e expected the nurses to n it was written by the PA. order should have been put uld have triggered the rs to the MAR so the nurses neter for placement, ensure ed each shift and the ered for dignity and the The DON could not say for asks were being done daily never made it to the MAR for that the task was I reported catheter care upon orientation with a return mually. The DON stated NA d on catheter care and she ow to clean a catheter	F	690			

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	-	D HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION		0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	i í			COMPLE	
				-		(	C
		345236	B. WING			11/	19/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	TE, ZIP CODE	
ACCORDI	US HEALTH AT WILMING	STON			820 WELLINGTON AVENUE		
					WILMINGTON, NC 28401		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
	1						
F 690	Continued From page	<u>.</u> 18	E	690			
1 030		ated 09/28/21 revealed;		090			
	indwelling urinary fole						
		ch) with 10 milliliter balloon					
	related to chronic urin	ary retention.					
	The Minimum Data S	ot (MDS) admission					
		/04/21 revealed Resident					
	#49 was nonverbal. H	le required two-person					
		with bed mobility, transfers,					
	-	living (ADL's). He had an					
	which were present o	nd multiple pressure wounds					
		0/11/21 revealed Resident					
	-	e in place for an indwelling					
		elated to sepsis and multiple e goal of care included					
	-	how no signs or symptoms					
		ough the review date.					
		l in part; to position the					
		ng below the level of the					
		oing for kinks every shift.					
	An observation of Res	sident #49 was conducted					
		M along with the wound					
		se #5). The foley catheter					
		ly 400 milliliters of urine was					
		resident's bed. The tubing lent #49 was awake and					
		or symptoms of pain or					
	discomfort were obse						
	An intonviour was care	ducted on 11/18/21 at 2:00					
		ne stated the nurse aide (#2)					
		ey bag in the resident's bed					
	after providing inconti						
	An intonviou was	ducted on 11/18/21 at 2:40					
		2. She stated she was an					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING				C 19/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMING	GTON			820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(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 690 F 842 SS=D	agency nurse and wa for Resident #49. She incontinent care to Re during her shift and st out of his room severa accidently left his fole during the last round been around 12:00 Pl aware the foley bag s the level of the bladde oversight. An interview was com PM with the Director of the Assistant Director stated she expected f completed accurately always be maintained bladder. Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re resident-identifiable to accordance with a cor agrees not to use or of except to the extent th to do so. §483.70(i) Medical re §483.70(i) In accor professional standard	s the assigned nurse aide e reported she provided esident #49 every 2 hours tated she had been in and al times and must have y catheter bag in his bed of care which would have M. She stated she was hould always be kept below er. She stated it was an ducted on 11/18/21 at 4:13 of Nursing (DON) along with of Nursing. The DON foley catheter care to be and the foley bag should I below the level of the tentifiable Information 483.70(i)(1)-(5) at-identifiable information. elease information that is o the public. lease information that is o an agent only in ntract under which the agent disclose the information he facility itself is permitted		842			12/17/21

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345236	B. WING				C 19/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT WILMING	STON			820 WELLINGTON AVENUE WILMINGTON, NC 28401			
(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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 842	<ul> <li>(ii) Accurately docume</li> <li>(iii) Readily accessible</li> <li>(iv) Systematically org</li> <li>§483.70(i)(2) The facial information contair regardless of the form records, except when</li> <li>(i) To the individual, or representative where</li> <li>(ii) Required by Law;</li> <li>(iii) For treatment, pay operations, as permitt with 45 CFR 164.506</li> <li>(iv) For public health a neglect, or domestic to activities, judicial and law enforcement purp purposes, research predical examiners, fu a serious threat to healthy and in compliance</li> <li>§483.70(i)(3) The faciare cord information agunauthorized use.</li> <li>§483.70(i)(4) Medical for-</li> <li>(i) The period of time</li> <li>(ii) Five years from the there is no requireme</li> <li>(iii) For a minor, 3 year legal age under State</li> <li>§483.70(i)(5) The medical state</li> </ul>	ented; e; and ganized lity must keep confidential hed 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, <i>v</i> iolence, health oversight administrative proceedings, tooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident;	F	842				

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		ND HUMAN SERVICES			PRINTED: 12/22/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345236	B. WING		C 11/19/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·
ACCORDI	US HEALTH AT WILMIN	GTON	820 WELLINGTON AVENUE		
ACCORDI				WILMINGTON, NC 28401	
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 842	Continued From pag	e 21	F 84	2	
	(iii) The comprehens	ive plan of care and services	1 04.	-	
	provided;	y preadmission screening			
	and resident review				
	determinations condu				
		e's, and other licensed			
	professional's progre				
		logy and other diagnostic			
	· ·	equired under §483.50. T  is not met as evidenced			
	by:	i is not met as evidenced			
		ons, record review, and staff		F842 Resident Records □ Iden	ıtifiable
		failed to document the		Information	
		ulin and indwelling urinary			
	-	rement for 2 0f 18 sampled			
		or medical record accuracy		1) On 11/18/21, the licensed r	
	(Resident #85 and #	15).		obtained clarification orders for	
	Findings Included:			#15 catheter to include securem	
	1/29/19 diagnoses w	admitted to the facility on		catheter tubing and documentat ordered. Resident #85 was disc	
	Diabetes Mellitus.	men meldded Type i		from the facility on 10/8/2021.	nargeu
	The quarterly Minimu	um Data Set (MDS)		2) Residents with insulin orde	rs were
		0/7/21 indicated Resident		audited by the DON on 11/18/20	
	#85 was moderately			additional concerns identified. C	
		cian orders listed the		11/18/21, the DON completed a	n audit of
	•	minister 15 units of Lispro		residents with catheters for com	
		ting insulin) subcutaneously		and accurate documentation. N	0
		e fat layer between the skin		additional concerns identified.	ad
	with a start date 10/7	e only for blood sugar 575 //21 at 6:30 PM		<ol> <li>The DON/Designee provide education to facility and agency</li> </ol>	
	Review of Resident #			nurses on 1) obtaining and valid	
		rd (MAR) for October 2021		catheter orders are complete ar	
		of Lispro insulin on 10/7/21		inclusive of size, tubing securen	
	at 6:30 PM was blan			catheter care and that care is p	rovided
		rse #4 was conducted on		and documented on the Treatm	
		Nurse #4 revealed she had		Administration Record (TAR) as	
		units of Lispro insulin on		and 2) following physician order	's and
		Nurse #4 stated she must		documentation of medication	
	nave forgotten to doo	cument it on the MAR.		administration. The licensed nu	rse will

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SU COMPLE			
		345236	B. WING		C 11/19	/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		•		
ACCORDI	US HEALTH AT WILMING	STON		820 WELLINGTON AVENUE WILMINGTON, NC 28401				
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 842	<ul> <li>F 842 Continued From page 22 <ul> <li>An interview was conducted with the Director of Nursing (DON) on 11/18/21 at 2:03 PM. The DON stated she expected the nurses to follow the Physician's orders and to document correctly on the MAR.</li> <li>2. Resident #15 was admitted to the facility on 27/02/42. Director of the table basis of the table basis.</li> </ul> </li> </ul>		F 84	<ul> <li>administer, and document instant catheter care as ordered by the catheter care as ordered by the Newly hired facility and agen nurses will receive education orientation.</li> <li>4) The Director of Nursing licensed nurse supervisor will audit of residents with 1) cather order completeness and TAF documentation as ordered by physician and 2) five (5) residents for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents with 1) cather orders for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and 2) five (5) residents and the completeness for documentation and the completeness for documentation and the completeness and th</li></ul>	the physician. cy licensed aduring and/or Il complete an neters for cy the dents with tion per the			
	prostate hypertrophy unstageable pressure The MDS dated 09/16 revealed resident #15 impaired and was alw and frequently inconti under hospice care. I an indwelling urinary assessment.	5/21 quarterly assessment is was severely cognitively rays incontinent of bladder nent of bowel and was Resident #15 did not have catheter during this		MAR of administration as orc physician. Monitoring will be a frequency of five (5) times four (4) weeks, then weekly f weeks and as necessary the Administrator will report findin monitoring to the Interdiscipli (IDT) during QAPI meetings three (3) months and will ma to the plan as necessary to n compliance with resident rec	completed at weekly for for eight (8) reafter. The ngs of the nary Team monthly for ke changes naintain			
	dated 11/17/21 reveal place for an indwelling intervention to include kinks. An observation of Res	#15 ' s updated plan of care led a plan of care was in g urinary catheter with an e check tubing each shift for sident #15 on 11/15/21						
	catheter draining con- urine. The bag was n the level of the bladde	had an indwelling urinary centrated amber colored loted to be hanging below er on the bed rail and the ot secured with a catheter						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345236	B. WING				C 19/2021
NAME OF PF	ROVIDER OR SUPPLIER		<b>I</b>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	CODE	
ACCORDI	US HEALTH AT WILMING	STON		820 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	not know why the cath secured to the residen hospice staff took car A review of the physic the electronic medica order to check placen shift. The Medication Admin November 18, 2021 r the initials of Nurse #2 checked the placeme the 7-3 shift. An observation of cath was conducted on 11, Nurse Aide (NA) #3. s room, provided priva applied gloves, raised lowered the bed shee proceeded to clean the the catheter was not s leg with a catheter str An interview was con- 11/18/21 2:35 PM. Na a nurse aide for 3 yea usually clean catheter should be secured to kinking. NA #3 stated was no strap to secur would let the nurse kr	0 AM. NA #4 stated she did heter tubing was not nt ' s leg. NA #4 stated the e of it. cian orders on 11/17/21 in I record (EMR) revealed an hent of catheter strap each nistration Record (MAR) for evealed a check mark and 2 indicating she had nt of the catheter strap on heter care for Resident #15 (18/21 at 2:15 PM with NA #3 entered the resident ' acy, washed her hands, I the resident ' s bed, ts, released the brief, and he catheter. The tubing to secured to the resident ' s ap. ducted with NA #3 on A #3 reported she had been ars but that she did not rs. NA #3 stated the tubing prevent the tubing from she was not sure why there e the catheter tubing and now that it was not secured. ducted with Nurse #2 via 12:15 PM. Nurse #2 stated e Aide had secured the	F	842			
	she thought the Nurse						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG_		C		
		345236 B. W		ING				
NAME OF PROVIDER OR SUPPLIER				e.	TREET ADDRESS, CITY, STATE, ZIP CODE	11/19/2021		
INAIVIE OF FROVIDER OR SUFFLIER					20 WELLINGTON AVENUE			
ACCORDIUS HEALTH AT WILMINGTON				WILMINGTON, NC 28401				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	N SHOULD BE COMPLETION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI			
1/10					DEFICIENCY)			
			1					
F 842	2 Continued From page 24		F 8	842				
	stated she did not check on the placement herself							
	to ensure the tubing was secured. Nurse #2							
	stated when she asked if the catheter care had							
	been done, NA #3 said it was so she assumed it included securing the catheter.							
		callelel.						
	An interview was conducted with the Director of							
	Nursing (DON) on 11/18/21 at 4:15 PM. The							
	DON reported nursing staff should not be signing							
	off tasks as completed unless they observed that							
	the task was actually	completed.						

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