DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				E I.	FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X:	3) DATE SURVEY COMPLETED
		345359	B. WING				C 04/08/2022
NAME OF P	ROVIDER OR SUPPLIER	·		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT CREEKS	SIDE CARE			TOKES STREET EAST		
				AHO	SKIE, NC 27910		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 0	00			
F 725 SS=D	from 4/5/2022 to 4/8/ The following intakes NC00185810, NC007 NC00187413. Three allegations were subs deficiencies. Event IE Sufficient Nursing Sta CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must have	186348, NC00187115, of the 17 complaint stantiated resulting in 0# 3Z2V11 aff (2) Staff. e sufficient nursing staff with	F 7.	25			4/11/22
	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re resident assessments and considering the r diagnoses of the facil	etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care					
	by sufficient numbers types of personnel or nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not					
		section, the facility must nurse to serve as a charge					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
	cally Signed						04/28/2022

**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.

OLNIEF	KS FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345359	B. WING		C 04/08/2022
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				604 STOKES STREET EAST	
ACCORD	IUS HEALTH AT CREEK	SIDE CARE		AHOSKIE, NC 27910	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 725	This REQUIREMENT by: Based on staff intern facility failed to provi residents received m one of four residents medication to contro two-day period (Resi Findings included: This citation is cross F760-Based on obse interviews and recom prevent a significant resident was not give insulin (Diabetic med glucose) over a two- one of four residents insulin (Resident#1). On 4/5/22 at 12:00 F sometimes the only n Medication Aides (M halls in the facility. N not take care of her n medications that the prn (when necessary Nurse #1 stated she her shift until the facility	T is not met as evidenced views and record review, the de sufficient staff so that redications as ordered for reviewed for insulin (diabetic l blood glucose) over a ident #1). referenced to: ervations, staff and physician d review, the facility failed to medication error when a en six doses of ordered dication to control blood day period. This occurred for reviewed for receiving PM, Nurse #1 stated she was hurse in the facility and A) were assigned the other urse #1 indicated she could residents and cover the MAs could not give, such as () medications and insulin. often had to stay over after lity could get someone to tated staffing had gotten	F 72	DEFICIENCY) 25 The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the s findings through informal dispute resolution, formal appeal proceedi any administrative or legal proceedi reserves all rights to raise all poss contentions and defenses in any ty civil or criminal claim, action or proceeding. Nothing contained in to of correction should be considered waiver of any potentially applicable Review, Quality assurance or self- examination privilege which the fa does not waive and reserves the r assert in any administrative, civil of criminal claim, action or proceeding facility offers its response, credible allegations of compliance and plar correction as part of its ongoing ef provide quality of care to residents F 725 / F760 / F835 1) Resident #1 □ Physician was r regarding missed insulin on 2/21/2	e survey ngs or dings. nt to ntract ty ible ype of this plan d as a e Peer critical cility ight to or g. The e n of forts to s
	not take care of her i medications that the prn (when necessary Nurse #1 stated she her shift until the fact come in. Nurse #1 st	residents and cover the MAs could not give, such as () medications and insulin. often had to stay over after lity could get someone to tated staffing had gotten		provide quality of care to reside F 725 / F760 / F835 1) Resident #1 □ Physician wa	as r 21/2 esic

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Facility ID: 923205

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		ND HUMAN SERVICES			FORM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345359	B. WING		C 04/08/2022
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT CREEKS	SIDE CARE		604 STOKES STREET EAST AHOSKIE, NC 27910	
(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	Continued From page		F 72	<ul> <li>the concerns with staffing and insuladiministration on 2/19/22 and 2/20. Daily Staffing Sheets were reviewe the timeframe of 2/19/22 to 4/08/22. Administrative Staff, Director of Nuland Regional Nurse Consultant. It was noted that over the course of the reperiod at no time were there less the three Licensed Nurses in the center the exception of 2/19/22 and 2/20/2 During the QAPI Meeting a plan was implemented to prevent recurrence staffing challenges related to call on Review of the schedule revealed the Licensed Nurse oversight of Certified Medication Aides was outlined on the staffing sheets.</li> <li>Nursing Administration reviewed the Medication Administration Records insulin administration for the halls we Certified Medication Aides assigned Licensed Nurse coverage from and hall from 2/19/22 through 4/08/22. Physician and Resident Represent any resident affected was notified. adverse were outcomes noted.</li> <li>3) Re-education regarding the staff deficiency, staffing review and staff expectations was provided by the Regional Director of Clinical Servic the Interim Assistant Administration Interim Director of Nursing on 4/10/20 On 4/6/22 notices with Administration were posted on every unit for the signal in the event of call outs which or the signal in the event of call outs which or the signal in the event of call outs which or the signal out of the signal ou</li></ul>	/22. d for by the rsing was eview han r, with 22. as of uts. he daily e for vith d with ther The ative of No fing ing es to and the /22. ve and ation taff to

Event ID: 3Z2V11

Facility ID: 923205

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/23/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345359	B. WING		C 04/08/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT CREEKS	IDE CARE		04 STOKES STREET EAST AHOSKIE, NC 27910	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 725	Continued From page	2.3	F 725	not be covered by the Staffing Coor or on-site designated nursing super Additional staffing contracts were executed to ensure that sufficient lic staff coverage would be secured to provide additional options should ca occur. The center has 13 active con agencies with two additional contract pending completion. Hiring for direct facility staff continue be a focus in addition to the use of contract staff. Administrative Staff/Nursing Administrative Staff and Staffing Coordinator review staffing scheduk the next 7 days to include weekends Monday □ Friday to ensure that the staffing pattern is filled with the appropriate number of licensed nurs and adjustments made as necessar meet the needs of the residents. Th monitoring is inclusive of the upcom weekend staffing levels. The Weeke Nurse Supervisor will review staffing Saturday and Sunday and make adjustments accordingly to assure resident needs are met. Staffing Hours are reconciled daily Monday through Friday for the prior with Fri/Sat/Sunday reconciled on M by the Staffing Coordinator, NHA or to confirm the staffing hours schedu licensed staff were worked as sched Staffing Hours are monitored on Sa and Sunday by the Weekend Nurse	visor. censed all outs ntract cts es to es for s, daily ses ry to is ning end g on day Monday DON lled for duled . turday

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Facility ID: 923205

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/23/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345359	B. WING		04/08/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	· · · · · · · · · · · · · · · · · · ·
ACCORD	US HEALTH AT CREEKS	IDE CARE		604 STOKES STREET EAST AHOSKIE, NC 27910	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 725	Continued From page	÷4	F	<ul> <li>725</li> <li>Supervisor to confirm the scheduled for licensed states as scheduled. The weeke supervisor will make adjusted additional staff as identified needs of the residents.</li> <li>Licensed Nursing Staff and Licensed Nursing Staff week Nursing Administration Lee Medication Administration administration from 4/8/22 Education will be ongoing Licensed Nurse receives the prior to the start of their new shift.</li> <li>Licensed Staff, both facilities needs of the center will be employed administration prior to the shift.</li> <li>Licensed Staff, both facilities new to the center will be employed administration prior to the shift.</li> <li>Administrator/designeed staffing weekly X 4 then months for review and reception administration administration prior to the supported the facility need the QAPI Committee months for review and receptions will be adjusted as a ssure compliance is sust.</li> <li>Weekly for four weeks the two months, Administration Records for have physician sorders for and documentation. Administration. Administration administration administration records for have physician sorders for and documentation. Administration. Administration administration administration for the staff for the st</li></ul>	staffing hours aff were worked end nurse stments and call ed based on the ad Contract ere educated by adership on including insulin 2 to 4/10/22. until each the education ext scheduled ty and contract, educated on including insulin start of their first ation/designee. e will review nonthly X 2 to hours worked ds and report to thly for three commendation. necessary to tained ongoing. en monthly for re Nursing Staff edication or residents who for insulin to administration

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/23/2022 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345359	B. WING		C 04/08/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT CREEKS	IDE CARE		604 STOKES STREET EAST AHOSKIE, NC 27910		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 725	Continued From page	÷5	F 72	5 Nursing Staff will complete any follow indicated. The Director of Nursing / Designee will report findings to the C Committee monthly for three months review and recommendation. Plans be adjusted as necessary to assure compliance is sustained ongoing. Completion Date: 04/11/2022	QAPI s for	
F 760 SS=D	CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on observatio and physician intervie facility failed to prevel error when a resident ordered insulin (diabe blood glucose) over a occurred for one of fo receiving insulin (Res Findings included:	ts are free of any significant is not met as evidenced ns, staff, Nurse Practitioner ews, and record review, the nt a significant medication was not given six doses of etic medication for control of two-day period. This ur residents reviewed for	F 76	<ul> <li>F 725 / F760 / F835</li> <li>1) Resident #1 □ Physician was not regarding missed insulin on 2/21/22 per the Physician statement Resider had no ill effects.</li> <li>2) On 4/08/22 a Quality Assurance Performance Improvement (QAPI) Committee Meeting was held to disc the concerns with staffing and insulia administration on 2/19/22 and 2/20/2</li> </ul>	and nt #1 cuss n	
	included Diabetes Me The Admission Minim 11/4/2021 noted Resi impaired for cognition Resident #1 got insuli	um Data Set (MDS) dated dent #1 was severely . The MDS indicated		Daily Staffing Sheets were reviewed the timeframe of 2/19/22 to 4/08/22 Administrative Staff, Director of Nurs and Regional Nurse Consultant. It w noted that over the course of the rev period at no time were there less that three Licensed Nurses in the center, the exception of 2/19/22 and 2/20/22 During the QAPI Meeting a plan was	by the sing vas view an , with 2.	

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						. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDIN	IG		
		345359	B. WING		C	
		545555	B. WING			08/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ACCORD	US HEALTH AT CREEK	SIDE CARE		604 STOKES STREET EAST AHOSKIE, NC 27910		
				•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 760	Continued From pag	je 6	F 7	60		
		evealed an order for Admelog		implemented to prevent	recurrence of	
		mealtime insulin) solution		staffing challenges relate		
		//milliliter (ml) insulin Lispro.		Review of the schedule		
		aneously with meals for		Licensed Nurse oversig		
	Diabetes.	-		Medication Aides was or	utlined on the daily	
				staffing sheets.		
		uary 2022 Medication				
		rd (MAR) revealed the insulin		Nursing Administration r		
		eduled for 8:00 AM, 12:00		Medication Administration		
		aily. The MAR indicated		insulin administration for		
		on the South Hall of the		Certified Medication Aid		
	facility.			Licensed Nurse coverag		
	0 4/5/0000 -+ 44-01			hall from 2/19/22 throug		
		5 AM, Medication Aide (MA)		Physician and Resident		
		and stated Medication Aides insulin. MA #1 stated she		any resident affected wa adverse were outcomes		
		administer insulin to her		adverse were outcomes	noteu.	
	assigned residents.			3) Re-education regard	ing the staffing	
	assigned residents.			deficiency, staffing revie		
	1a. On 2/19/22, the l	MAR revealed no		expectations was provid		
		Resident #1 received insulin		Regional Director of Clir	2	
		neals. The spaces for those		the Interim Assistant Adr		
		ot checked or initialed.		Interim Director of Nursi		
	A roviow of the staffi	ng sheet for 2/19/22 noted		On 4/6/22 notices with A	dministrative and	
		lowing staff assignments:		Nursing Leadership con		
		ident #1's hall): Medication		were posted on every ur		
	Aide (MA) #3	action in the many. Modification		call in the event of call o		
	- East: Nurse #4			not be covered by the S		
	- East Annex: Nu	rse #1		or on-site designated nu	-	
	- West: MA #2			Ŭ Ŭ	<u> </u>	
	- West Annex: MA	A #4		Additional staffing contra	acts were	
	The staffing sheet fu	rther revealed Nurse #4		executed to ensure that		
	(assigned to the Eas	t Hall) called out of work on		staff coverage would be	secured to	
	2/19/22.			provide additional option	ns should call outs	
				occur. The center has 1		
		0 AM, MA #3 was interviewed		agencies with two additi	onal contracts	
		assigned to the South Hall on		pending completion.		
	2/19/22. She was u	nable to recall if someone				

Facility ID: 923205

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP		STRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			· · ·	IPLETED
							С
		345359	B. WING			04	4/08/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET	ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT CREEKS			604 ST	OKES STREET EAST		
ACCORDI	US REALTH AT CREEKS	SIDE CARE		AHOS	KIE, NC 27910		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 760	Continued From page	e 7	F 76	0			
	had administered inst residents on 2/19/22.	8		be	ing for direct facility staff continue a focus in addition to the use of ntract staff.	es to	
		ducted with Nurse #3 on who stated she worked 7:00		hΔ	ministrative Staff/Nursing		
		2:00 AM on 2/19/22. Nurse			ministrative Staff and Staffing		
	#3 stated on 2/19/202	22 staff had not come in for			ordinator review staffing schedul	es for	
	their shift to relieve he	er. Nurse #3 indicated she			e next 7 days to include weekend	s, daily	
		tant Administrator, who told			onday □ Friday to ensure that the		
		ry to find a replacement for			iffing pattern is filled with the		
		after thirty minutes she had			propriate number of licensed nurs		
		ut a replacement and she dministrator, who told Nurse			d adjustments made as necessar eet the needs of the residents. Th		
		ement for her. Nurse #3			phitoring is inclusive of the upcom		
	indicated she explain				ekend staffing levels. The Week	-	
		ning and could not stay.			rse Supervisor will review staffing		
	Nurse #3 stated the A	Assistant Administrator told		Sa	turday and Sunday and make	-	
		uld just worry about her		-	justments accordingly to assure		
		covering for the Medication		res	sident needs are met.		
		ed a Medication Aide came					
		ounted the cart with her so			affing Hours are reconciled daily	dov	
	she could leave.				onday through Friday for the prior h Fri/Sat/Sunday reconciled on N		
	On 4/5/2022 at 12:00	PM Nurse #1 was			the Staffing Coordinator, NHA or		
		d Medication Aides could		-	confirm the staffing hours schedu		
		. Nurse #1 stated there was			ensed staff were worked as sched		
	a time when she was	the only nurse in the facility			affing Hours are monitored on Sa		
		s on the rest of the halls.			d Sunday by the Weekend Nurse		
		did not give all the insulins at			pervisor to confirm the staffing ho		
		tated she could not take			neduled for licensed staff were we	orked	
	care of her residents	and cover insulin entire building, that it was			scheduled. The weekend nurse	nd call	
	too much for any one	-			pervisor will make adjustments ar ditional staff as identified based c		
		F			eds of the residents.		
	On 4/6/2022 at 3:45 I	<sup>⊃</sup> M an interview was					
	conducted with the As	ssistant Administrator who		Lic	ensed Nursing Staff and Contrac	t	
	-	on a Saturday morning			ensed Nursing Staff were educat	-	
		remember what time. The			rsing Administration Leadership		
	Assistant Administrat	or indicated that Nurse #1		Me	edication Administration including	insulin	

Facility ID: 923205

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION		E SURVEY IPLETED
			A. DOILDII	<u> </u>			С
		345359	B. WING			04	/08/2022
AME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				60	04 STOKES STREET EAST		
CCORDI	US HEALTH AT CREEKS	SIDE CARE		Α	HOSKIE, NC 27910		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 760	Continued From page	2.8	E -	760			
1 700				100	administration from 1/8/22 to 1/10/22		
		ut a lot of things, and that ften and was possessive			administration from 4/8/22 to 4/10/22. Education will be ongoing until each		
		n the East Annex Hall. The			Licensed Nurse receives the education	h	
		or noted she told the nurses			prior to the start of their next scheduled		
	to figure it out. When	asked who would give			shift.		
	insulin for the medica	ition aides, the Assistant					
		she had not been working at			Licensed Staff, both facility and contra	ct,	
		and that rules were very			new to the center will be educated on		
		medication aides could do in			Medication Administration including ins		
		ı Texas, which was where she wasn ' t totally familiar			administration prior to the start of their shift by Nursing Administration/designed		
		Assistant Administrator			Shint by Nursing Administration/designe	ee.	
		el she needed to call the			4) Administrator/designee will review		
		e she felt she had handled			staffing weekly X 4 then monthly X 2 to	C	
	it. She stated she wa	s not aware Resident #1 did			validate the schedules to hours worked		
	not get insulin that da	ay.			supported the facility needs and report		
					the QAPI Committee monthly for three		
		022 during a follow up			months for review and recommendatio		
		nt Administrator was asked if			Plans will be adjusted as necessary to		
		staffing for the facility on			assure compliance is sustained ongoir	ıg.	
		y was that she did not really bened, but she assumed the			Weekly for four weeks then monthly fo	r	
		it, and she did not hear			two months, Administrative Nursing St		
	anything else about it	-			will review five random Medication	an	
	, , ,				Administration Records for residents w	/ho	
	1b. On 2/20/22 the M	IAR revealed no			have physician□s orders for insulin to		
		Resident #1 received insulin			validate compliance with administration	n	
		eals on those two days. The			and documentation. Administrative		
	•	lications were not checked			Nursing Staff will complete any follow-	up	
	or initialed	a sheat for 2/20/22 poted			indicated. The Director of Nursing /	וח	
		ng sheet for 2/20/22 noted owing staff assignments:			Designee will report findings to the QA Committee monthly for three months for		
		dent #1's hall): Medication			review and recommendation. Plans w		
	Aide (MA) #3				be adjusted as necessary to assure		
	- East: MA #2				compliance is sustained ongoing.		
	- East Annex: Nur	se #1					
	- West: Nurse #2				Completion Date: 04/11/2022		
	- West Annex: MA	44	1				1

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			FOF	ED: 05/23/202 RM APPROVEI IO. 0938-039
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED	
345359	B. WING		04	C 4/08/2022
·	ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
	604 STOKES STREET EAST			
DIDE CARE	AH	IOSKIE, NC 27910		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
AM, MA #3 was interviewed assigned to Resident #1 on 0/22 during the first shift b. She revealed she asked to the East Annex Hall) and to the West Hall) to #1's insulin, but neither ister the insulin. She raid he might have a reaction to insulin, so she made him ee him. MA #3 stated have any negative effects sulin on 2/20/22. 7/2022 at 11:01 AM, Nurse to n 2/20/22 during the first ed the West Hall. Nurse #2 assigned the East Annex alls were assigned to the West Hall. Nurse #2 assigned the East Annex alls were assigned to the West Hall and the signed halls also. Nurse #2 ministrator told her she rear her hall and the b. Nurse #2 told her she rese #2 indicated the or told her it should not be a ver those halls, and Nurse bolem. Nurse #2 stated she residents on her assigned to #2 said that taking care of t 's needs took all her time ver insulin for a medication	F 760			
	ATEMENT OF DEFICIENCIES TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	MEDICAID SERVICES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE ( A. BUILDING         345359       B. WING         SIDE CARE       ID PREFIX TAG         ATEMENT OF DEFICIENCIES PY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         AF       PREFIX TAG         AG       PREFIX TAG         PO AM, MA #3 was interviewed assigned to Resident #1 on 00/22 during the first shift ). She revealed she asked o the East Annex Hall) and o the West Hall) to #1's insulin, but neither ister the insulin. She raid he might have a reaction is insulin, so she made him isee him. MA #3 stated have any negative effects sulin on 2/20/22.         7/2022 at 11:01 AM, Nurse d on 2/20/22.         7/2022 at 11:01 AM, Nurse	MEDICAID SERVICES         (x1) PROVIDER/SUPPLIENCIA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A. BUILDING         345359       B. WING         345359       B. WING         SIDE CARE       STREET ADDRESS, CITY, STATE, ZIP CO 604 STOKES STREET EAST AHOSKIE, NC 27910         ATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC DEENTIFYING INFORMATION)       ID PREFIX TAG         CROSS-REFERENCED TO TO DEFICIENCE       PREFIX (EACH CORRECTIVE ACTION (EACH CORRECTIVE A	UD HUMAN SERVICES     FOR MEDICAID SERVICES     OMB N       (1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:     (x2) MULTIPLE CONSTRUCTION A BUILDING     (x3) AU       345359     B. WING     0       30DE CARE     STREET ADDRESS, CITY, STATE, ZIP CODE 604 STOKES STREET EAST AHOSKIE, NC 27910     0       ATEMENT OF DEFICIENCIES OF MUST GE PRECEDED BY FULL SCIENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCE ACTION SHOLLD B

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345359	B. WING _			C 08/2022
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
ACCORDI	US HEALTH AT CREEKS	IDE CARE		604 STOKES STREET EAST AHOSKIE, NC 27910		
(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 760	Continued From page	9 10	F7	760		
F 835 SS=D	Assistant Administrate West Hall was support was the usual protoco Assistant Administrate remember talking to N should be able to cov medicines and she st be able to take care of cover the medication On 4/8/2022 at 2:18 F was interviewed by te stated he knew about to Resident #1, and h the facility a day or tw he had no ill effects fr physician stated he m but he had reviewed to they were fine. Administration CFR(s): 483.70 §483.70 Administration A facility must be administration or practicable physical, for well-being of each rest This REQUIREMENT by: Based on record revision interviews, the facility provide oversight and facility had sufficient so medication administrate	or indicated she did Nurse #2 and telling her she er the medication aides' ill thought the nurses should of their own residents and aide's insulin too. PM, Resident #1's physician lephone. The physician the insulin not being given e had seen Resident #1 in ro after that happened and om missing the insulin. The may not have written a note, the blood sugar values and on. inistered in a manner that esources effectively and maintain the highest mental, and psychosocial	F	R35 F 725 / F760 / F835 1) Resident #1 □ Physician was notifir regarding missed insulin on 2/21/22 ar per the Physician statement Resident a had no ill effects.	nd	4/11/22

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345359	B. WING		04/08/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	•
ACCORD	US HEALTH AT CREEKS				
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 835	insufficient staffing. T residents reviewed fo to control blood gluco Findings included: This citation is cross F760- Based on obse physician interviews, facility failed to preve error when a resident ordered insulin (diabe blood glucose) over a occurred for one of for receiving insulin (Res F725- Based on staff review, the facility fail so that residents rece ordered for one of fou insulin (diabetic medi	his was for one of four or diabetic medications (used ose) (Resident #1). referenced to: ervations, staff, and and record review, the nt a significant medication t was not given six doses of etic medication for control of a two-day period. This our residents reviewed for sident #1). interviews and record led to provide sufficient staff	F 83	<ul> <li>2) On 4/08/22 a Quality Assurat Performance Improvement (QAR Committee Meeting was held to the concerns with staffing and in administration on 2/19/22 and 2/ Daily Staffing Sheets were revie the timeframe of 2/19/22 to 4/08 Administrative Staff, Director of and Regional Nurse Consultant. noted that over the course of the period at no time were there less three Licensed Nurses in the cet the exception of 2/19/22 and 2/2 During the QAPI Meeting a plan implemented to prevent recurrer staffing challenges related to cal Review of the schedule revealed Licensed Nurse oversight of Cer Medication Aides was outlined o staffing sheets.</li> <li>Nursing Administration reviewed Medication Administration Recool insulin administration for the hall Certified Medication Aides assig Licensed Nurse coverage from a hall from 2/19/22 through 4/08/2 Physician and Resident Represe any resident affected was notifie adverse were outcomes noted.</li> <li>3) Re-education regarding the s deficiency, staffing review and s expectations was provided by th Regional Director of Clinical Ser the Interim Assistant Administration Interim Director of Nursing on 4/</li> </ul>	PI)         discuss         sulin         '20/22.         wed for         /22 by the         Nursing         It was         e review         s than         nter, with         :0/22.         was         ore of         I outs.         d that         tified         n the daily         I the         rds for         Is with         ned with         another         2. The         entative of         rd. No         staffing         e         vices to         or and the

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345359		(X2) MULTIPLE	OMB NO. 0938-039 (X3) DATE SURVEY				
			A. BUILDING	COMPLETED			
		345359	B. WING		C		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/08/2022		
			e	04 STOKES STREET EAST			
ACCORDI	US HEALTH AT CREEKS	SIDE CARE		AHOSKIE, NC 27910			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION		
F 835	Continued From page	e 12	F 835		nation staff to n could pordinator pervisor. licensed to call outs contract racts hues to of lules for nds, daily he urses sary to This poming ekend ing on e		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		
IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
345359		B. WING		
IER		STREET ADDRESS, CITY, STATE, ZIP CODE	04/08/2022	
REEKSIDE CARE		604 STOKES STREET EAST AHOSKIE, NC 27910		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION S	IOULD BE COMPLETIC	
n page 13	F 83	<ul> <li>to confirm the staffing hours so licensed staff were worked as a Staffing Hours are monitored of and Sunday by the Weekend N Supervisor to confirm the staffing scheduled for licensed staff were as scheduled. The weekend n supervisor will make adjustmer additional staff as identified base needs of the residents.</li> <li>Licensed Nursing Staff and Co Licensed Nursing Staff were ear Nursing Administration Leaders Medication Administration incluation administration from 4/8/22 to 4 Education will be ongoing until Licensed Nurse receives the ear prior to the start of their next so shift.</li> <li>Licensed Staff, both facility and new to the center will be educated Medication Administration incluation incluation prior to the start shift by Nursing Administration.</li> <li>4) Administrator/designee will staffing weekly X 4 then month validate the schedules to hours supported the facility needs an the QAPI Committee monthly fimonths for review and recommittee monthly for four weeks then more weekly for four weekly for four weeks then more weekly for four weeks then more weekly for four weeks then more weekly for four weekly for four weeks then more weekly for four weeks then more weekly for fo</li></ul>	scheduled. n Saturday Jurse ng hours re worked urse nts and call sed on the ntract ducated by ship on iding insulin /10/22. each ducation cheduled d contract, ited on iding insulin of their first /designee. review ly X 2 to s worked d report to or three uendation. ssary to d ongoing. onthly for	
	IDENTIFICATION NUMBER: 345359 IER REEKSIDE CARE MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL	ARE & MEDICAID SERVICES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIP A. BUILDING         345359       B. WING         IER         REEKSIDE CARE         MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG	RE & MEDICAID SERVICES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         345359         IER         STREET ADDRESS, CITY, STATE, ZIP CODE 604 STOKES STREET EAST AHOSKIE, NC 27910         IER         REEKSIDE CARE         ID PREFIX FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)         TAG         PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3)         ID PREFIX TAG         PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3)         ID PREFIX TAG         PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3)         ID PREFIX (EACH CORRECTIVE ACTION 3)         TAG         ID PREFIX (EACH CORRECTIVE ACTION 3)         TAG         ID PREFIX TAG         TO confirm the staffing hours sc licensed staff were worked as s Staffing Hours are monitored o and Sunday by the Weekend N Supervisor to confirm the staffi scheduled. The weekend n supervisor will make adjustmer additional staff as identified bas needs of the residents.         Licensed Nursing Staff and Co Licensed Nursing Staff and Co Licensed Nursing Staff were ec Nursing Administration Leaders Medication Administration Inclu administration from 4/8/22 to 4 Education will be ongoing until Licensed Nu	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/23/202 // APPROVE ). 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345359	5359 B. WING			C 04/08/2022	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CREEKSIDE CARE				ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
					04 STOKES STREET EAST		
				A	HOSKIE, NC 27910		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 835	Continued From page	÷ 14	F	835	Administration Records for residents have physician s orders for insulin t validate compliance with administrati and documentation. Administrative Nursing Staff will complete any follow indicated. The Director of Nursing / Designee will report findings to the O Committee monthly for three months review and recommendation. Plans be adjusted as necessary to assure compliance is sustained ongoing. Completion Date: 04/11/2022	o ion v-up QAPI 5 for	

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