	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED		
		345236	B. WING		C 01/20/2023		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
				820 WELLINGTON AVENUE			
ACCORDI	JS HEALTH AT WILMIN	IGTON		WILMINGTON, NC 28401			
(X4) ID			ID	PROVIDER'S PLAN OF C			
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE DATE		
E 000	Initial Comments		E 00	00			
		certification survey was					
		09/2023 through 01/20/2023. Ind in compliance with the					
	requirement of CFR	. 483.73 Emergency					
F 000	Preparedness. Even		F 00	0			
1 000		5	1.00				
	A recertification surv	• •					
	•	nducted from 01/09/23					
		vent ID #7KD011. The re investigated: NC00196297,					
	NC00195892, and N						
	3 of the 8 complaint	-					
	substantiated resulti	-					
	Notify of Changes (I CFR(s): 483.10(g)(1	njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 58	30	2/20/23		
	§483.10(g)(14) Notif						
	., .	nediately inform the resident;					
		dent's physician; and notify, r her authority, the resident					
	representative(s) wh						
		lving the resident which					
		has the potential for requiring					
	physician interventio	n; nge in the resident's physical,					
	mental, or psychoso						
	deterioration in heal	th, mental, or psychosocial					
		nreatening conditions or					
	clinical complication (C) A need to alter tr	s); reatment significantly (that is,					
		e an existing form of					
	treatment due to adv	verse consequences, or to					
	commence a new fo	-					
		nsfer or discharge the					
	resident from the fac	cility as specified in					

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.

02/14/2023

	-	ID 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 20/2023
NAME OF P	ROVIDER OR SUPPLIER	•		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT WILMING	GTON			320 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	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 580	 (ii) When making noti (14)(i) of this section, all pertinent informatic is available and provious physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must rupdate the address (r phone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must disclose its physical configurat locations that comprise part, and must specific room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on observatio interviews, and Physi failed to notify the Phy- resident abuse (Reside the Physician for misse (Resident #22 and Resident) 	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment I0(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations to is not met as evidenced ns, record review, staff cian interviews, the facility ysician of an allegation of dent #44) and failed to notify sed doses of medications	F	580	F580 POC Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: A) The attending physician is currently aware of the abuse allegation involving Resident #44. B) The attending physician is currently)	

Event ID: 7KD011

Facility ID: 923408

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		MEDICAID SERVICES			OMB NO. 0938-
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			5 M/NO		С
		345236	B. WING		01/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
ACCORDI	JS 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 PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DAT
F 580	Continued From page				
F 300	Continued From page		F 58		and Decident
		admitted to the facility on ses that included bipolar		aware that Resident #22 a #14 did not receive their n	
	disorder, anxiety, and			prescribed and Medication	
	, e, e, e	5 ·F····9····		Reports have been compl	
	The quarterly Minimu	m Data Set (MDS)		Address how the facility w	
		/17/22 revealed Resident		residents having the poter	
	#44 was cognitively in			affected by the same defic	cient practice:
		he MDS also indicated the		Desidents who reside in th	a faailitu haya
	resident was ambulat	ory.		Residents who reside in the been identified as having	
	The initial 24-hour rer	port alleged resident to staff		be affected.	
	altercation was faxed			Address what measures v	vill be put into
	Personnel Registry th	e facility indicating resident		place or systemic changes	
		lent #44 and Nurse Aide		ensure that the deficient p	ractice will not
	(NA) #5 on 11/24/22 a	at approximately 9:15 PM.		recur:	
		on report by the previous		A) The Regional Vice Pres	
		d this investigation did not		Operations will educate th	
	include any mention of			Administrator and the Dire	5
	- ,	PA-C) were notified of a abuse allegation event the		on notifying the Medical D allegation of abuse post a	-
	evening of 11/24/22.	a abuse allegation event the		the resident(s) involved. T	
				Vice President of Operation	•
	A Psychotherapy Prog	gress Note dated 11/28/22		the Nursing Home Admini	
		aled Social Worker reported		completion of the Facility	
		ident #44 was assaulted by		Incident Completion Chec	klist. This
	• • • •	The Social Worker (SW)		Checklist indicates the tim	-
		dent was witnessed, and		abuse occurred and the til	me the attending
		called in to speak with		physician was notified.	t Coordinator
	resident. Patient den flashbacks exaggera	ted startle response, or		B) The Staff Developmen Assistant Director of Nurs	
	change in moods.			Nursing or Nurse Supervis	
	J			the Certified Medication A	
	An interview on 01/10)/23 at 12:13 PM with the		their scope of practice and	. ,
	Psychiatrist (PhD) rev	ealed the SW told him that		the Certified Medication A	-
		rd about Resident #44's		Licensed Nurse if medicat	-
	-	ation incident was from		available. The Staff Devel	-
	SW contacted him the	lay) 11/25/22. He said the		Coordinator, Assistant Dir Director of Nursing or Nur	U 1

Facility ID: 923408

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		MEDICAID SERVICES	-			NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
	CONTECTION	DENTIFICATION NUMBER.	A. BUILDING	3		
						С
		345236	B. WING			01/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE		
				WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From pag	e 3	F 58	50		
		trauma assessment for		will educate the Licensed Nurs	ses to notify	
		<i>i</i> th Resident #44. The Ph-D		the attending physician to obta		
	_ · · ,	the facility on 11/28/22, he		orders if medication is missed		
		#44's 11/24/22 abuse		available or if medication is no		
	allegation event, and	the PA-C told him that this		administered due to medication	n	
		e heard of the 11/24/22		parameters and when to comp		
		aid it was his expectation that		Medication Variance Report.	-	
		sician and/or PA-C should		classroom orientation period t		
		ely notified that same		Development Coordinator will		
	-	#44's alleged abuse and		newly hired Certified Medicatio		
	wasn't.			their scope of practice and wil		
	An intonviow on 01/1	1/23 at 1:35 PM with Nurse		the Certified Medication Aides Licensed Nurse if medication	-	
		rse at time of 11/24/22		available. During their classro	•	
		between Resident #44 and		orientation period the Staff De		
	NA #5. The Night Ch			Coordinator will educate newly		
	-	nt immediately after they		Licensed Nurses to notify the		
		Resident #44 was taken to		physician to obtain further ord	-	
	· ·	e escorted NA #5 to her car.		medication is missed, not read		
	Nurse said that night	he had a three-way phone		or if medication is not adminis	tered due to	
	call with the Administ	trator and the Director of		medication parameters and w	hen to	
	Nursing (DON), but c	lid not remember if he called		complete a Medication Varian	ce Report.	
	the on-call Physician	or not.		After 2/20/23 no CMA or Licer		
				will be permitted to work without	•	
	An interview on 01/12			the aforementioned education		
		ician #1 revealed he was		Development Coordinator or N	lursing	
		ician and was also the		Supervisor.		
		evening of 11/24/22.		Indicate how the facility plans		
	-	as his expectation that he or		its performance to make sure	Inat	
		e been notified of Resident		solutions are sustained:		
		on 11/24/22. He said the first of Resident #44's abuse was		A) The Nursing Home Adminis	strator will	
		/28/22. He said he was		complete the Facility Reportat		
	-	1/24/22, and the nurse		Completion Checklist for any a		
	should have called h			abuse. Upon completion, the I	-	
		in, saturat.		Reportable Incident Completion		
	An interview on 01/1	2/23 at 1:05 PM with		will be scanned to the Regiona		
		PA-C) revealed it was her		President of Operations or Re		
		or the MD should have been		President of Clinical for review	-	

Facility ID: 923408

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		MEDICAID SERVICES				<u>OMB NO. 0938</u> I	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTIO		(X3) DATE SURVEY COMPLETED	ſ
		345236	B. WING			C 01/20/202	3
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRES	S, CITY, STATE, ZIP CODE		
ACCORD	IUS HEALTH AT WILMING	GTON		820 WELLINGTO WILMINGTON,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPI	(5) LETIO ATE
F 580			F 5	30			
	wasn't. She said she abuse allegation was	44's abuse on 11/24/22 and first became aware of the on 11/28/22 from the PhD. 8/23 at 4:53 PM with the		allegation Reportable will be pres	Idation. Monthly for any of abuse, the completed Fact e Incident Completion Checkl sented by the Nursing Home Itor to the Quality Assurance	list	
	Regional Clinical Vice President (RCVP) revealed she expected nursing staff to follow their facility's notification policy to notify the on-call Physician for any incidents of abuse which was not done for Resident #44 on 11/24/22.			Committee review the recommen sustained B) Five tim the Directo of Nursing Coordinato Supervisor	mance Improvement (QAPI) e. The QAPI Committee will Checklist and make idations to assure compliance ongoing. hes a week for twelve weeks, or of Nursing, Assistant Direc , Staff Development or, Unit Manager or Nursing r will perform medication tion pass observation audits	e is tor	
	2. Resident #22 was 08/29/16.	admitted to the facility on		ten resider documenta administra	nts daily to include ation of medication tion pass and to validate n is administered per physicia		
	08/22/18 an order for milligrams (mg) one of day for GERD, an ord Valproic Acid Solution give 625 mg by mout schizoaffective disord	cian orders revealed on Prilosec (Omeprazole) 20 capsule by mouth one time a der written on 06/11/20 for n 250 mg per 5 milliliters (ml) h two times daily for der, and an order written on e 10 mg by mouth one time		notification missed me will be pre- Nursing (D Assurance Improveme three moni- review the	rell as observation for of attending physician for an edication. Results of the audit sented by the Director of OON) in the monthly Quality e and Performance ent (QAPI) Meeting monthly f ths. The QAPI Committee wil audits and make indations to assure compliance	ts for II	
	review for Resident # 01/03/23, 01/04/23, 0 01/09/23, and 01/10/2 order for 625 mg had AM dose on 01/02/23 recorded for both dos on 01/04/23, 01/05/23	nistration Record (MAR) 22 revealed on 01/02/23, 01/05/23, 01/06/23, 01/08/23, 23 the Valproic Acid Solution the #9 recorded for the 9:00 3, and 01/03/23 and the #9 ses (9:00 AM and 9:00 PM 3, 01/06/23, 01/08/23, 23. The MAR revealed on		sustained	-		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345236	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER			Ş	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	01/08/23 and 01/11/2 mg had the #9 record 01/09/23 and 01/11/2 order for Prilosec 20 r review of the key cod #9 meant to "see nurs A review of the electro administration notes f 01/02/23 revealed the indicated "waiting on and 01/04/23 the note Solution was "on orde indicated the Valproic "reordered." There w 01/05/23, 01/06/23, 0 indicating why the Val given. On 01/08/23, to indicated the Cetirizin and on 01/11/23 the r pharmacy." On 01/08/ indicated the Prilosec stock," and on 01/11/2 "contacting pharmacy note indicating why th 01/09/23. Review of the Physici for the month of Janu Nurse's station for ha was no documentatio Resident #22 had not Cetirizine, or Prilosec An interview was con- (MA) #2 on 01/11/23 a 01/02/23 she docume see nurses' notes for	3 the order for Cetirizine 10 ed and on 01/08/23, 3 the MAR revealed the mg had the #9 recorded. A ing on the MAR revealed the se's notes." Onic medication for Resident #22 on a Valproic Acid Solution note pharmacy," On 01/03/23 a indicated the Valproic Acid er," and on 01/08/23 the note Acid Solution was ere no medication notes for 1/09/23, or 01/10/23 proic Acid Solution was not the medication note e 10 mg was "out of stock," note indicated "contacting /23 the medication note 20 mg order was "out of 23 the note indicated ." There was no medication ne Prilosec was not given on ans' communication book ary 2023 located at the lls 500/600 revealed there in to indicate notification that a received her Valproic Acid,	F	580			

Facility ID: 923408

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DEPARTMENT OF HEALTH AI CENTERS FOR MEDICARE &					FORM	0: 02/22/2023 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	345236	B. WING	_	C 01/20/2023			
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
ACCORDIUS HEALTH AT WILMIN	GTON		320 WELLINGTON AVENUE WILMINGTON, NC 2840				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
 was not available on Cetirizine, and the P the medication cart of room on 01/11/23 an medications were not An interview with Nu PM revealed she cot aware by MA #2 on 0 Acid Solution was not and she further state the Cetirizine or the I not available and we on 01/11/23. Nurse # the physician. An interview was cor Manager (UM) on 01 stated the Medication communicate with th was unavailable and notify the physician i available to be given An interview was cor 01/13/23 at 12:14 PM worked on the medic to the Charge Nurse stated on 01/03/23, 0 recorded the #9 for t Resident #22 on the see the medication in could not remember had been reordered. An interview was cor 01/13/23 at 12:47 PM 	ved she told Nurse #10 it 01/02/23. MA #2 stated the rilosec were not available on or in the medication storage tod she told Nurse #10 the ot available. rse #10 on 01/11/23 at 3:30 uld not recall if she was made 01/02/23 that the Valproic ot available for Resident #22, ed MA #2 did not inform her Prilosec medications were re not given to Resident #22 #10 stated she would notify nducted with the Unit 1/11/23 at 3:10 PM. The UM in Aides were trained to reir nurses if a medication the nurses were trained to f a medication was not d. MA #5 reported when she cation cart, she would report assigned to that hall. She 01/09/23, and 01/10/23 she he Valproic Acid Solution for MAR because she did not in the drawer. She stated she if she asked the nurse if it	F 580					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/22/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		SURVEY LETED
		345236	B. WING			C 01/20/2023		
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
ACCORDI	US HEALTH AT WILMING	GTON			20 WELLINGTON AVENUE			
				v	VILMINGTON, 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 580	communication book nursing station that th	he noted in the Physician's which was kept at the le medications were not esident #22 did not receive	F	580				
	NP stated Resident # Solution to treat schiz stated she was not av receiving the medicat receiving the medicat #22 to have breakthro potential for negative stated she was not av received her Cetirizing interview, the physicia reviewed for January documentation to indi received any of these A phone interview witt (PA) on 01/13/23 at 3 the first time she was not receiving her Valp Cetirizine. She stated to be notified after mis doses of the Prilosec would have wanted to was missing any dose stated the resident has schizoaffective disord could have caused he She stated if nurses a documenting medicat would expect them to	11/13/22 at 1:10 PM. The 22 was getting Valproic Acid coaffective disorder. She ware the resident was not ion as ordered and that not ion could cause Resident bugh symptoms with the side effects. The NP also ware Resident #22 had not e or Prilosec. During this an communication book was 2023 and there was no cate Resident #22 had not medications. h the Physician Assistant :50 PM revealed this was hearing about Resident #22 proic Acid, Prilosec, or d she would have expected ssing 1 and no more than 2 and Cetirizine, but she o have been notified if she es of the Valproic Acid. She is a history of ler and missing those doses er to become unbalanced. and medication aides were ion "not available," she be following up on the ure it was available and to						

Facility ID: 923408

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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 COMF	SURVEY PLETED
		345236	B. WING				C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMING	GTON		820 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 580	Continued From page	8	F	580			
	President on 01/13/23 expectation of the Me sure the Charge Nurs a medication was not Nurse should be notif resident did not receiv ordered.	Regional Clinical Vice 3 at 4:55 PM revealed her edication Aides was to make ses were being notified when available, and the Charge tying the Physician anytime a we their medications as					
	Review of the physici was written on 05/12/ 10 mg; one tablet dail	an's order revealed an order 22 for Atorvastatin Calcium ly for high cholesterol and on Lisinopril tablet 2.5 mg; give gh blood pressure.					
	(MAR) for January 20 #9 was documented b Atorvastatin. The Lis have the letter "X" rec #4, and on 01/07/23 a under the blood press	ation Administration Record 123 revealed on 01/03/23 the by Nurse #12 for the inopril order was noted to corded on 01/06/23 by MA and 01/08/23 by MA #6 sure with the #9 and #5 at to see nurses' notes.					
	by Nurse #12 on 01/0 Atorvastatin was "not	available," and on 01/06/23 nd 01/08/23 by MA #6 the					
	for the month of Janu Nurse's station for ha was no documentatio	ans' communication book ary 2023 located at the Ils 500/600 revealed there n to indicate notification received her Lisinopril or					

Facility ID: 923408

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/22/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING			C 01/20/2023		
NAME OF PI	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT WILMING			82	0 WELLINGTON AVENUE			
ACCOUND		51014		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		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 580	Continued From page		F 5	80				
	Alorvasialin medicali	JIIS.						
	01/11/23 revealed the so she documented the	dication Aide (MA) #4 on E Lisinopril was not available he #9 on the MAR "not I she could not remember if not on 01/06/23.						
		ho recorded the #5 and #9 /23 and 01/08/23 was not iew.						
	Nurse #12 who record Atorvastatin on 01/03, interview.	ded the #9 for the /23 was not available for an						
	PM revealed the Atom were both available in unit and if the Medica her know there was n she would have remo medication dispensing MA #4 nor MA #6 eve	se #11 on 01/13/23 at 12:47 vastatin and the Lisinopril in the medication dispensing tion Aide came to her to let one available on the cart, ved them from the g unit. She stated neither re came to her regarding ations not being available for						
	The PA stated she wa #14 had not received stated if nurses and n documenting medicat would expect them to medication to make s notify her for additional An interview with the	PA) on 01/13/23 at 3:50 PM. as not made aware Resident these medications. She nedication aides were ion "not available," she be following up on the ure it was available and to						

Facility ID: 923408

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	1		LETED
		345236	B. WING _				C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			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	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 580	sure the Charge Nurs a medication was not Nurse should be notif	e 10 dication Aides was to make es were being notified when available, and the Charge ying the Physician anytime a ve their medications as	F 5	580			
F 584 SS=E	Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(F 5	584			2/20/23
	§483.10(i) Safe Enviro The resident has a rig comfortable and hom- but not limited to rece supports for daily livin	yht to a safe, clean, elike environment, including iving treatment and					
	homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall ex	ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident thes not pose a safety risk. xercise reasonable care for esident's property from loss					
		eeping and maintenance maintain a sanitary, orderly, ior;					
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are					
	§483.10(i)(4) Private resident room, as spe	closet space in each cified in §483.90 (e)(2)(iv);					

If continuation sheet Page 11 of 78

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345236	B. WING		C 01/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	US HEALTH AT WILMING			820 WELLINGTON AVENUE	
Accordi		Sien		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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 584	Continued From page §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initia 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio facility failed to: 1a) fa linoleum in 3 of 13 res 603), 1b) failed to ren substance from the co of 13 resident rooms 1c) failed to ensure th damaged drywall in 2 and 600 halls), 1d) fa cabinet door in 1 of 1 failed to replace roug hand-rails on the 500 repair leaking commo rooms (506, 508, 510 repair drywall wall da rooms (501, 508, and broken or missing floo rooms (502, 508, 600 615), and 1i) failed to blinds in 2 of 13 resid Findings included:	e 11 te and comfortable lighting table and safe temperature lly certified after October 1, a temperature range of 71 to maintenance of comfortable is not met as evidenced is not met as evidenced ins and staff interviews the ailed to repair torn floor sident rooms (508, 600, and hove the black greenish formode base caulking in 4 (506, 508, 510, and 615), ne ceilings were free from of 4 shower rooms (500 iled to repair a broken wall 3 resident rooms (502), 1e) h, worn, splintered and 600 halls, 1f) failed to ode bases in 4 of 13 resident b, and 612). 1g) failed to mage in 3 of 13 resident (615), 1h) failed to replace for tile in 8 of 13 resident b, 609, 610, 612, 614, and replace broken window ent rooms (600 and 613).	F 584	4 F584 POC Address how corrective action will b accomplished for those residents fo have been affected by the deficient practice: The torn floor linoleum in resident ro 508, 600, and 603 has been repaired The black greenish substance from commode base caulking in resident rooms 506, 508, 510 and 615 has b cleaned or replaced. The ceilings th had damaged drywall in the shower in 500/600 shower rooms have beel repaired. The broken wall cabinet in resident room 502 has been repaired The rough, worn, splintered handraid the 500 and 600 halls have been re The leaking commode bases in resil rooms 506, 508, 510, and 612 have repaired. The drywall damage in re rooms 501, 508 and 615 has been	und to poms ed. the reen nat rooms n n ed. ils on paired. dent e been sident
	revealed torn floor lin rooms (508, 600, and	n 01/10/23 at 2:20 PM oleum in 3 of 13 resident l 603). 1b. An observation on revealed 4 of 13 resident		repaired. The floor tile has been rep in resident rooms 502, 508, 600, 60 610, 612, 614 and 615. The window blinds have been replaced in reside	9, <i>N</i>

Facility ID: 923408

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		MEDICAID SERVICES					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDIN	NG			С
		345236	B. WING			0	1/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				82	20 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMIN	GION		W	ILMINGTON, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 584	Continued From page	e 12	F.5	584			
		8, 510, and 615), were noted			rooms 600 and 613. All repairs were		
		sh substance located around			completed by 2/19/23.		
	-	nodes. 1c. An observation			Address how the facility will identify of	ther	
	on 01/10/23 at 2:20 F	PM revealed 2 of 4 facility			residents having the potential to be		
	-	nd 500 halls) were noted to			affected by the same deficient practic	e:	
	have damaged ceiling						
		/23 at 2:20 PM revealed 1 of			Observational audits have been		
		all cabinet door broken,			conducted by the Administrator and	of	
		n one hinge in 1 of 13 . 1e. An observation on			Maintenance Director to identify areas concerns to include torn floor linoleum		
	,	revealed 500 and 600 halls			black greenish substance from the	1,	
		ere rough, worn, with multiple			commode base caulking, shower roor	n	
		ne 500 and 600 halls. 1f. An			ceilings with drywall damage, broken		
	observation on 01/10	/23 at 2:20 PM revealed 4 of			cabinets, rough, worn, splintered		
		nmodes were leaking at their			handrails, leaking commode bases,		
		wage smell eminating from			drywall damage, floor tile and broken		
	-	rooms (506, 508, 510, and			window blinds. On 2/13/23 a Quality		
		ation on 01/10/23 at 2:20 PM dent rooms repair were			Assurance Performance Improvemen Plan was developed to address the	τ	
		I wall damage (501, 508, and			identified areas prioritizing any risk an	eas	
	-	tion on 01/10/23 at 2:20 PM			Address what measures will be put in		
		dent rooms with broken or			place or systemic changes made to		
		2, 508, 600, 609, 610, 612,			ensure that the deficient practice will r	not	
		observation on 01/10/23 at			recur:		
		of 13 resident rooms with					
	broken window blinds	s (600 and 613).			The Administrator and Regional Vice		
	An interview and faci	the tour of the EOO and EOO			President of Operations educated the		
		Ity tour of the 500 and 600 with the Maintenance			Maintenance Director on the process attaining/maintaining a homelike	101	
		10/23 at 2:20 PM. The MD			environment. In addition, the facility s	staff	
	, ,	Itiple areas on the 500 and			have been educated by the Staff	-	
		eded to be addressed,			Development Coordinator or a member	er of	
	repaired, or replaced	. He stated he had had no			the Administrative Team on the proces		
		Il able to keep up with faclity			for completing maintenance requests		
		did not know what the black			areas that are not homelike including		
		ctually was around some of			floor linoleum, black greenish substar		
		e 500 and 600 halls, and did			from the commode base caulking, sho	ower	
	THOLKING ADOUT THE RE	eaking commodes. MD said		1	room ceilings with drywall damage,		

Facility ID: 923408

If continuation sheet Page 13 of 78

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
						С
		345236	B. WING			01/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				820 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMING	GTON		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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC	CTION SHOULD BE	(X5) COMPLETIO DATE
IAG	REGULATORY OR			DEFICIEN		
F 584	Continued From page	a 13	F 58			
			1.50		ing commodo	
		es, and that maintenance		splintered handrails, leak bases, drywall damage, f		
	-	epairing or replacing items in				
		he broken or missing floor		broken window blinds. Af will not be permitted to we		
	-	d, because he ordered				
		12/19/22, and were still on		receiving the aforementio		
	back order.			by the Staff Development		
	A	1.4 4		member of the Administra	auve ream, or	
		lity tour was conducted with		Nursing Supervisor.		
		esident of Operations		Indicate how the facility p	long to monitor	
		at 11:30 AM. She identified		Indicate how the facility p		
		oncern, she observed during		its performance to make solutions are sustained:	sure inal	
	the tour of the facility,	e 500 and 600 halls. She		solutions are sustained.		
				Five times a week for twe	lvo wooko tho	
	said their current Qua	-				
	-	ement Action (QAPI) Plan		Administrator, Maintenan		
		was not specific enough to		Director of Nursing, Staff		
		idents physical environment		Coordinator and select de	•	
		d 600 halls. She stated, the		will conduct observationa		
		ere currently, not home-like.		resident rooms to include		
		al concerns included:		linoleum, black greenish		
	•	ance work orders, repair and		the commode base caulk	•	
		ent rooms/bathrooms, repair		room ceilings with drywal		
		des, repair or replace of		broken wall cabinets, rou		
		binets, and repair or replace		splintered handrails, leak	•	
	-	l physical physical plant		bases, drywall damage, f		
		d to be addressed. The		window blinds. Results o		
		er expectation for all the		observational audits will b		
	residents to have a sa			the Administrator or Main		
		clean and in good repair.		in the monthly Quality Ass Performance Improvement		
	A follow-up observation	on and facility tour of the 500		meeting monthly for three	. ,	
	and 600 halls on 01/1			QAPI Committee will revi		
		D. The tour revealed: 2 of 2		and make recommendation		
		nd 600 halls) ceilings had		their findings to assure co		
	damaged ceiling dryw	, -		sustained ongoing.	L	
		around the base of 4 resident				
		, 510, and 615), leaking or				
		06, 508, 510, and 612),				
		worn, rough, with splintering				

Facility ID: 923408

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345236	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	IUS 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 584	areas (500 and 600 h rooms with torn lonell tiles. The Maintenance the facility did not utili order system (TELS), management platform with integrated asset and maintenance solu checked the paper we the nursing stations e that most of the facilit communicated by the communicated by the communication and n He stated he did not n walk-throughs of the additional maintenance addressed in work order safety concerns. MD system in place to tra maintenance, and als documentation of com orders that still neede A follow-up interview Regional Vice Preside on 01/12/23 at 2:00 P additional maintenance other sister facilities to facility concerns she is storage boxes of floor the missing and broke on 01/11/23, and were the torn lenolium and A follow-up interview Regional Clinical Vice	alls), and multiple residents ium and missing or broken are Director (MD) indicated ize fully their electronic work which was a building in disigned for senior living management, life safety, utions. He stated he ork order binders located at every morning, and added y's repair needs were e staff through verbal to by paper or electronically. routinely complete routine facility to address any ce needs that were not der binders. He stated he requests based on resident stated he did not have a ck regular scheduled facility to could not provide inpleted or pending work ed to be addressed. was conducted with the ent of Operations (RVPO) PM. She stated the ce personnel she pulled from o address the additional identified, found in facility's r tiles, and have replaced en tile in Resident #44 room e in the process of repairing broken window blind. was conducted with the e President (RVP) on She said their current	F	584			

Facility ID: 923408

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			X3) DATE SURVEY COMPLETED	1
						С	
		345236	B. WING			01/20/202	3
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMIN	GTON			20 WELLINGTON AVENUE /ILMINGTON, NC 28401		
					PROVIDER'S PLAN OF CORRECTION	~	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPL	(5) LETION ATE
F 584	Continued From page	e 15	F	584			
		(QAPI) Plan that addressed		004			
		al environment on the 500					
		idenify all the facility's					
		ns, problem, or issues.					
F 600	Free from Abuse and	l Neglect	F	600		2/20/2	23
SS=D	CFR(s): 483.12(a)(1))					
	§483.12 Freedom fro Exploitation	m Abuse, Neglect, and					
	•	right to be free from abuse,					
		ation of resident property,					
		efined in this subpart. This					
	includes but is not lim						
		, involuntary seclusion and					
		nical restraint not required to					
	treat the resident's m	iedical symptoms.					
	§483.12(a) The facilit	ty must-					
	§483.12(a)(1) Not us	e verbal, mental, sexual, or					
	physical abuse, corpo	oral punishment, or					
	involuntary seclusion						
		Γ is not met as evidenced					
	by:	ious staff maniplant and			F000 DOC		
		iew, staff, resident, and view, the facility failed to			F600 POC Address how corrective action will be		
		right to be free from physical			accomplished for those residents found t	to	
		lents reviewed for abuse			have been affected by the deficient		
	(Resident #44).				practice:		
	Findings included:				The facility is not able to correct the actions of NA #5 and how she responder	d	
	Resident #44 was ad	lmitted to the facility on			to Resident #44 on 11/24/22. NA #5 was		
		ses that included bipolar			suspended per facility policy on 11/24/22		
	•	sphagia, gastrostomy, vocal			NA #5's employment with the facility was		
	cord cancer with old				terminated as a result of her interactions with Resident #44. Resident #44 did not		
			1			1	

Event ID: 7KD011

Facility ID: 923408

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					OMB NO. 0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BOILDING	G	с	
		345236	B. WING		01/20/2	2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
		CTON .		820 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMIN	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CA THE APPROPRIATE	(X5) OMPLETIC DATE
F 600	Continued From page	- 16				
1 000			F 60			
	#44 was cognitively in	2/17/22 revealed Resident		#5's actions. A Facility Re and 5-day report were sul		
		he MDS also indicated the		regulation regarding the a	-	
		tory, required enteral tube		abuse.		
		agia and eating nothing by		Address how the facility w	ill identify other	
	mouth (NPO).	5 5 5 ,		residents having the poter	-	
				affected by the same define		
	Resident #44 's care	plan dated 11/14/22		-		
	revealed resident had	d an Activities for Daily Living		Residents who reside in the	ne facility have	
		rmance deficit relate to		been identified as having	-	
		ad a behavior problem		be affected. NA #5 was su	-	
		esident's rooms and taking		11/24/22. Abuse educatio		
		long to her from other		on 11/25/22 as a result of NA #5.	the actions of	
		ns. Resident was resistive to to anorexia and was not		Address what measures v	vill be put into	
		g by mouth (NPO) order		place or systemic change	-	
		Resident had potential		ensure that the deficient p		
		lated to tube feedings due to		recur:		
	supraglottic squamou					
		diet order, and would eat		On January 2, 2023, the F	Regional Vice	
		ng machines and other		President of Clinical Servi		
	sources. Per care pla	in initiated		the Director of Nursing the	e facility abuse	
	11/16/22-12/20/22, S	taff were instructed, when		policy. On January 2, 202	3, the Regional	
		s agitated: Intervene before		Vice President of Clinical		
		uide away from source of		educated the Interim Nurs	0	
	distress; engage caln	-		Administrator the facility a	buse policy.	
		ve, staff to walk calmly away,				
	and approach later.			On 1/23/23 the Regional		
	The initial 24 hour re-	nort alleged resident to staff		Clinical Services educated	•	
	altercation was faxed	port alleged resident to staff		Home Administrator and t Nursing on notifying the M		
		ne facility indicating resident		any allegation of abuse po		
		dent #44 and Nurse Aide		of the resident(s) involved		
		at approximately 9:15 PM.		Regional Vice President c		
	, ,			Services educated the Nu		
	The 5-day investigation	on report by the previous		Administrator on completi	_	
		ked to the Health Care		Reportable Incident Comp		
	Personnel Registry o	n 12/01/22 and indicated		This Checklist indicates th		
	Resident #44 had a h	nistory of not being truthful		alleged abuse occurred a	nd the time the	

Facility ID: 923408

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345236	B. WING		n [,]	1/20/2023
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		.,20,2025
				820 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMIN	GTON		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S			(X5) COMPLETIO DATE
F 600	Continued From pag	e 17	F 60	0		
	regarding her behavi	ior and would deny or attempt justify her action(s) when		attending physician was noti	fied.	
		and questioned by staff.		The Nursing Home Administ	ator, Director	
	Statements taken fro	m staff members who were		of Nursing, Staff Developme	nt	
	present during Resid			Coordinator, Assistant Direct		
		ewed. The Administrator's		or Nurse Supervisor will edu		
		summary revealed "From		including agency staff, on the	•	
		, it has been determined that d to stop Resident #44 from		abuse policy, what to do if th suspect abuse and how to re		
	-	okies which had been left at		behavioral resident. After 2/2		
		y a family as a holiday treat		will be permitted to work with		
	•	not safe for Resident #44 to		the aforementioned education	-	
	consume. When NA	#5 attempted to remove		Nursing Home Administrator	, Director of	
	candy and cookies fr	om resident's possession,		Nursing, Staff Development	Coordinator,	
		e aggressive punching NA		Assistant Director of Nursing	, or Nursing	
		ushing her. Skin checks		Supervisor.		
		no alteration to skin integrity		- · · · · · · · · · · · · · · · · · · ·		
		idents capable to interview		The Nursing Home Administr		
		estioned regarding staff any concerns noted. A		Development Coordinator, N Supervisor, or a member of t		
	traumatic/stressful e	-		Administrative Team will edu		
		atric evaluation on 11/14/22		hired staff during their orienta	-	
		44 had delusional (religious),		on the facility's abuse policy,		
		and irritability. A Psychiatric		they witness or suspect abus		
		onducted on 11/28/22 when		respond to a behavioral resid		
	-	se between Resident #44		Indicate how the facility plan		
)#5 on 11/24/22 was first		its performance to make sure	e that	
		indicated that the allegation		solutions are sustained:		
		altercation, and NA #5 was			. N.L	
		lure to redirect resident		Weekly for twelve weeks, the	-	
		n-services on abuse were an in-service was conducted		Home Administrator, Social S Director, Social Worker, Dire		
	•	-direct residents during		Nursing, Staff Development		
	episodes of aggressi	-		Assistant Director of Nursing		
				Supervisor will randomly inte		
	A review of a written	statement by NA #5		staff members to validate the		
		ght of 11/24/22, Resident #44		of abuse, what to do if they v	-	
	-	ing station going through		suspect abuse and how to re		
	snacks on the desk.	مرافا مام ممر ممر المامة الم		behavioral resident. Anyone	ملطم مبيرة مطير	

Facility ID: 923408

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 0938 (X3) DATE SURVE COMPLETED	
		345236	B. WING		C 01/20/202	23
NAME OF PI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETIOI ATE
F 600	Continued From page behind the nursing st	e 18 ation. Resident #44 was	F 60	0 to answer correctly will be imm	ediately	
	moving the cans and hit me in the face and calling me a n, me. I pushed her aw me in the face, eye, li off. I do not know if I An interview was con 01/19/23 at 12:35 PM voice messages on s voice mail box not be phone on 01/19/23, a answered, after a lon was NA #5, and agre on 11/24/22 around 7 was observed behind she explained to the HIPAA law. NA #5 said the front of the nursin over the front over the front over the front over the front over	g pause, she confirmed she ed to an interview. She said (:30 - 8:00 PM Resident #44 I the nursing station, which resident was against the id the resident went back to g station and was reaching nursing station reaching for she then walked up to the nd the resident proceeded to er hips, then suddenly the		 removed from the work area ar re-educated until they can state correct responses. The results audits will be presented by the Home Administrator in the mon Assurance and Performance Improvement (QAPI) Meeting r three months. The QAPI Comm review the audits and make recommendations to assure co sustained ongoing. The Nursing Home Administrat complete the Facility Reportabl Completion Checklist for any a abuse. Upon completion, the F Reportable Incident Completion will be scanned to the Regiona President of Operations or Reg President of Clinical for review recommendation. Monthly for a allegation of abuse, the complet Reportable Incident Completion will be presented by the Nursin Administrator to the Quality Ass and Performance Improvement Committee. The QAPI Commit review the Checklist and make recommendations to assure co sustained ongoing. 	e the of the Nursing thly Quality nonthly for nittee will mpliance is or will le Incident llegation of acility n Checklist I Vice jional Vice and my eted Facility n Checklist g Home surance t (QAPI) ttee will	
	39 years as an NA, the before. She then said statement and walked	d her to her car. gress note dated 11/28/22				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/22/2023 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING		_	(01/:	C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
			8	20 WELLINGTON AVENUE	E		
ACCORDI	US HEALTH AT WILMING	JTON	v	VILMINGTON, NC 2840	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600		e 19 ted startle response or	F 600				
	change in moods. An interview was com 01/10/23 at 11:45 AM awhile back, she thou December/2022, a fei the front of her neck w a box of chocolates a Resident #44 said she when she spoke with want to get anyone fir could not remember to or the staff member w neck. Resident #44 s the nursing station, sh chocolates sitting their member that she could candy. Resident #44 see what kind of choco the staff member grate #44 said she later tolo was never in any pair member grabbed her startled that the staff func- An interview was con- on 01/10/23 at 12:13 revealed he came to fa assess Resident #44 (SW) told him about F	ducted with Resident #44 on 1. Resident #44 revealed ught somewhere in male staff member grabbed when she was just looking at t the nursing station. e refused to press charges the police officer and did not red. Resident #44 said she he date, shift, time of day, who grabbed the front of her stated when she walked to he saw a big box of re and was told by a staff Id not have any of the she said she just wanted to colates were in the box when obed her neck. Resident d her psychologist that she h during or after the staff neck, only that she was					
	evaluate Resident #4 see how she was. He and then let the Socia trauma assessment. seemed fine after he	1 11/28/22, his goals were to 4 emotional status and to e said he saw the resident al Worker know about his He said Resident #44 completed the trauma ychologist said the trauma					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/22/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345236	B. WING			(01/2) 20/2023
NAME OF PR	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
	US HEALTH AT WILMING	NTON .	8	20 WELLINGTON AVENUE			
ACCORDI	US REALTH AT WILMING	SION	v	VILMINGTON, NC 28401	l		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page evaluation revealed th no Post Traumatic Str no nightmares. He sa emotionally Resident obvious physical sign An interview was con- 01/11/23 at 1:35 PM. the night supervisor of evening Medication A immediately after Res altercation at the nurs he interviewed all par escorted NA #5 out of while MA #3 sat with Nurse #4 said he call and Director of Nursir assessed Resident #4 with MA #3 present, w no physical injury, and the resident. He said was that she did not w Nurse #4 said when the body-cam assessment present, which reveal #4 said he then condu- residents' rooms on the residents voicing condo- An interview was con- 01/11/23 at 4:55 PM re- saw Resident #44 gra- were left at the nursin staff by families for the #5 told the resident the	e 20 he resident had no trauma, ress Disorder (PTSD), and aid his job was to make sure #44 was okay and had no s of abuse. ducted with Nurse #4 on Nurse #4 revealed he was n 11/24/22. Nurse said that ide (MA) #3 came to him sident #44 and NA #5's ing station. Nurse #4 said ties involved and then the building to her car, Resident #44 in her room. ed the Police, Administrator, ng. He said he then 14's body and neck area which revealed no bruising, d no emotion or crying from resident's only concern, vant NA #5 to lose her job. he police arrived, they did a to of Resident #44, with him ed no physical injury. Nurse ucted safety checks of all he 600-hall, with no cerns.	F 600				
	not have anything by was lightly tapping the	mouth. MA #3 said NA #5 e resident's hand while please drop the chocolates					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/22/2023 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING		_	01/:	; 20/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			8	20 WELLINGTON AVENUE	E		
ACCORDI	US HEALTH AT WILMING	STON	v	VILMINGTON, NC 2840	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page she had in her hand. then started to push N walked around to the and said she did not of When the resident rea snacks which were or station, NA#5 tried ag away from the food at #44 punched NA #5 in glasses off. MA#3 sai on the front of Reside the resident away with to prevent more punce #3 said she then got it took the resident to he until the police arrived had no pain, no short distressed. MA#3 sai who saw the event. M remember NA#5 sque with her right hand. M reflex, to grab and pu being punched in the MA#3 said NA#5 did the resident but she s An interview was conto 01/11/23 at 5:05 PM. as she entered the far area door, she obserview hand on the front of R	A 21 MA#3 said the resident NA#5, and then the resident inside of the nursing station care and wanted the snack. ached for the other holiday in the inside of the nursing pain to push resident's hand ind that was when Resident in the left eye, knocking her id NA#5 put her right hand int #44's neck, trying to push in her right hand while trying hes from the resident. MA in-between them both and er room where she stayed b. MA#3 said the resident in ess of breath, and was not id she was the only witness MA#3 said she did not eezing the resident's neck MA#3 said it was an instant sh the resident away after left eye on her glasses. not intentionally try to choke hould have walked away. ducted with NA #3 on NA #3 revealed on 11/24/22 cility through the smoking yed NA #5 with her right resident #44's neck. NA #3	F 600				
	her because she was coming inside from th #3 said the distance w #5 had squeezed Res did see NA #5's right resident's neck. NA #	#44 nor MA#3 could see behind them as she was, e smoking area door. NA vas too far away to see if NA sident #44"s neck, but she hand was on the front of the 3 then said MA #3 got separated them. NA #3					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345236	B. WING			LD BE COMPLET	-
NAME OF PF	ROVIDER OR SUPPLIER		•	ŝ	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)		COMPLETION
F 600	the police arrived and taken off the floor and night supervisor. An interview was com AM with the Police De detective revealed he video body cam asses Resident #44 dated 1 Nurse #4 in attendand the body cam assess and neck showed no neck area. The detect couple of interviews to #44's case of assault/ An interview was com Clinical Vice Presiden 4:53 PM. The RCVP Administrator no long RCVP stated the prev investigation of the 11 was not abuse. She s that NA #5 pushing R spontaneous reflex re the face. RCVP felt b that NA #5 should have	escorted to her room until NA #5 was immediately l escorted to her car by the ducted on 01/13/23 at 10:35 etective. The police reviewed the police officer's ssment conducted on 1/24/22 at 10:22 PM with ce. The detective revealed ment of Resident #44's body injury around her body or tive said he still had a to conduct and that Resident ducted with the Reginal at (RCVP) on 01/13/23 at stated the previous er worked at the facility.	F	600			
	Accuracy of Assessm CFR(s): 483.20(g)	ents	F	641			2/20/23
	resident's status.	of Assessments. t accurately reflect the [·] is not met as evidenced					

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		ATE SURVEY
		345236	B. WING			C 01/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE 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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 641	Continued From pag	e 23	F 64	1		
	Based on record rev facility failed to accur Data Set (MDS) asse	iew and staff interviews the ately code the Minimum essments for medications 24) and for falls (Resident		F641 POC Address how corrective action accomplished for those reside have been affected by the def practice:	nts found to	
1. Resident # 11/02/22. Dia	Findings included:			Resident #24 quarterly MDS of 11/7/2022 was modified on 1/2	16/23 to	
	11/02/22. Diagnoses	admitted to the facility on included major depressive rder, and anxiety disorder.		reflect the accuracy for medica Resident #35 quarterly assess modified on 1/10/23 to reflect accuracy for falls.	sment was	
	revealed Resident #2	assessment dated 11/07/22 24 was cognitively intact and eiving any antianxiety his review period.		Address how the facility will id residents having the potential affected by the same deficient	to be practice:	
	Clonazepam (medica	vas written on 11/02/22 for ation to treat anxiety) 0.5 tablet by mouth every 12 anxiety.		Residents with medications ar been identified as having the p be affected. Residents with me and residents who have exper had their Minimum Data Set (I audited by the MDS Coordinat	ootential to edications ienced falls MDS)	
	for November 2022 r	cation Administration Record evealed Resident #24 Clonazepam from 11/02/22		validate accuracy of the MDS Resident Assessment Instrum Manual. Audit was completed Address what measures will b place or systemic changes ma	per the ent (RAI) on 1/30/23. e put into	
	4:10 PM revealed sh #24 had an order for	S Nurse #1 on 01/13/23 at e overlooked that Resident Clonazepam, and she had		ensure that the deficient pract recur:	ice will not	
	MDS should have no medication.	ne MDS nurse stated the ted she received anti-anxiety		MDS Coordinators were educa 1/23/23 by the Regional Vice I Clinical Services on MDS codi sections J1700, J1800, J1900	President of ing of	
	President on 01/13/2 expected the MDS n	Regional Clinical Vice 3 at 4:25 PM revealed she urses to accurately nts' assessments per the		N per the RAI Manual. Indicate how the facility plans its performance to make sure solutions are sustained:		

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM): 02/22/2023 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		LETED
		345236	B. WING			C 20/2023
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641 F 689 SS=D	05/06/22. Diagnoses with right sided weak Review of a nurse's n 11:30 PM revealed th resident lying on his b bed. No bleeding, ope bruising were noted. I normal and vital signs was helped back to b The MDS quarterly as revealed Resident #3 impaired and required two staff physical ass daily living and had in upper and lower extre not noted as having a assessment review. An interview with MDS 4:10 PM revealed she #35 had a fall on 11/2 been noted in the MD An interview with the President on 01/13/23 expected the MDS nu document the resident guidelines and that th status. Free of Accident Haza CFR(s): 483.25(d)(1)	admitted to the facility on included, in part, stroke ness. ote written on 11/23/22 at e nurse had observed the pack on the floor beside the en wounds, skin tears, or His range of motion was a were stable. Resident #35 ed and was able to rest. seessment dated 01/06/23 5 was severely cognitively d extensive assistance with istance with activities of pairment on one side to his emities. Resident #35 was ny falls during this S Nurse #1 on 01/13/23 at e overlooked that Resident 4/22 and that it should have S as one fall with no injury. Regional Clinical Vice B at 4:25 PM revealed she rses to accurately ts' assessments per the e assessments reflect their ards/Supervision/Devices (2)	F 64	Weekly for twelve weeks the MDS Coordinators will audit three Minimum Data Sets per week to validate coding the RAI Manual of residents prescribed medications and resident who experier falls. The MDS Coordinators will not self-audit. Results of the audits will be presented by the MDS Coordinator in t monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	i nce he	2/20/23
	§483.25(d) Accidents	·				

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		D HUMAN SERVICES MEDICAID SERVICES			FORM APPRON OMB NO. 0938-03	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345236	B. WING		01/20/2023	
NAME OF PI	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 689	The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio interviews, the facility to prevent accidents H was identified by the f smoker" (Resident #6 assessed as "not a cu #43) to smoke cigare for 2 of 5 residents of in the designated smo Findings included: Review of the facility (Revised 11/2/2022), Healthcare has chose building. However, st smoke outside the bu smoking area, under assigned staff monito a. Resident #67 was 08/19/21 with diagnos adult failure to thrive, mental status, age rel tobacco use. Review of a quarterly 12/28/22 documented	 we that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced n, record review and staff failed to provide supervision by allowing a resident who facility as a "supervised i7) and a resident who was urrent smoker" (Resident ttes without staff supervision beerved smoking cigarettes being area. policy, "Smoking Policy" documented: "August en to be a smoke free mokers will be allowed to ilding at the designated the supervision of an r." admitted to the facility on ses that included dementia, encephalopathy, altered ated physical debility, and MDS assessment dated I Resident #67 had intact t tired on 2 to 6 days during 	F 689	 F689 POC Address how corrective action will be accomplished for those residents found have been affected by the deficient practice. Resident #43 had smoking assessmer completed on or before 2/29/23 by the Director of Nursing, Assistant Director Nursing, Unit Manager or Nursing Supervisor. The facility is unable to retro-correct the lack of supervision concern identified for resident #67 and resident #43 during the survey. Smoki materials for resident #67 were secure by the facility for the residents' future uprior to the survey exit. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice. On 1/20/23 the Director of Nursing, Assistant Director of Nursing, Unit Manager conducted a 100% interview audit of all residents to ensure the facility is aware of all residents who smoke. The residents identified will have an update smoking assessment completed to 	ts of Ing d se Ier :	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				DRM APPROVE NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · ·	ATE SURVEY OMPLETED	
		345236	B. WING			C 01/20/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 26	F 6	89			
	required extensive assistance from staff with all activities of daily living except for walking, locomotion and eating which required supervision. He had one fall since admission to the facility.			determine their level of supervi required. Resident care plans updated accordingly by the ME Coordinators.	will be		
		rs List provided on 01/09/23 ented Resident #67 was a		On February 10, 2023, the Adr and Director of Nursing review smoking policy, to include the s schedule with staff assignment the identified residents who sm	ed the smoking s, with all		
	03/02/22 with diagnos	admitted to the facility on ses that included hemiplegia wing a cerebral infarction		concerns were addressed by the Administrator or Director of Nu	ne		
	a history of tobacco u			The Admission's Coordinator w the smoking policy with all new residents.			
	assessment dated 01 moderately impaired sleepy on 12-14 days back period. He had	Minimum Data Set (MDS) /07/23 documented he had cognition. He felt tired and a during the assessment look an impairment on one side ver extremities. He had		Address what measures will be place or systemic changes ma ensure that the deficient praction recur:	de to		
	received both schedu medications.	lled and as needed pain		On or before 2/20/23 Licensed were educated by the Staff De Coordinator, Director of Nursin Manger on completing a smoki	velopment g or Unit		
	-	assessment dated 10/03/22 t #43 as "not a current		assessment upon admission, of and with a significant change in The smoking assessment will of	uarterly condition. determine		
	01/11/23 revealed five designated smoking a facility staff were pres area. A resident who			the level of supervision require care plan will be updated by th Coordinator or Nurse Supervis the resident's desire to smoke supervision. On 2/14/23 the R	e MDS or to reflect and level of egional		
	cigarette to smoke an In an interview with N	d providing Resident #43 a nd a cigarette lighter. lurse Aide #1 on 01/11/23 at nere was no staff member to		Vice President of Clinical Servi educated the MDS Coordinato Nursing Supervisors on implen smoking care plans for residen as smokers.	rs and nenting		

Facility ID: 923408

						. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	(X3) DATE : COMPL		
		345236	B. WING			С	
	ROVIDER OR SUPPLIER	545256		STREET ADDRESS, CITY, STATE, ZI		20/2023	
	ROVIDER OR SUFFLIER			820 WELLINGTON AVENUE	FCODE		
ACCORDI	US HEALTH AT WILMING	GTON		WILMINGTON, 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 689	Continued From page	a 97	F 6	280			
1 000				009			
		r 's because the Patient Care normally took the smoker 's		A Smoking Binder has b	een implemented		
		was off and no one else had		for the Smoking Monitor	-		
		stated she would go out and		Smoking Binder is a con			
	•	its who were smoking but		which contains the level			
		code to the door to access		required for each reside	5		
		had to leave the area to		Monitors were educated			
	obtain the code. Whe	-		Administrator or Director	U		
		ents who were smoking for		Smoking Binder, to go o			
	the remainder of the l	break.		residents to the designate when observing smoking	-		
	The facility Administra	ator was called to the		all smoking paraphernal			
	-	area on 01/11/23 during the		smoke break. The Smok			
		k to observe the process.		updated by the Director			
	He stated the residen	its should not have had		Assistant Director of Nu	-		
		ettes and lighters) in their		Manager or Nursing Sup			
		e should have been a staff		needed basis based on			
		the residents who were		and changes of condition	n.		
		led he would straighten out		After 2/20/22 pe stoff will	I ha normitted to		
		nowledged the potential fire tely instructed staff to collect		After 2/20/23 no staff wil work without receiving the	-		
		arettes and lighters) from		education from the Direct			
		them in a locker near the		Staff Development Coor	-		
		as previously designated for		Director of Nursing, or N			
		storage when the items were		Supervisor.	5		
				Newly hired licensed nu			
		ne Reginal Clinical Vice		nurses will receive educ			
		3 at 8:45 AM she stated she		completing a smoking as	-		
	•	outside with the smokers to		admission, quarterly and			
		f the risk of resident 's She acknowledged it was a		change in condition prior their next scheduled shift			
		so expected cigarettes and		new hire orientation by t	-		
		a secure, locked area when		Development Coordinate			
		d not expect any resident to		Supervisor.			
		ettes or lighters on their					
	person or in their rooi	-		During their classroom c	rientation newly		
				hired Smoking Monitors			
				by the Administrator, Dir	ector of Nursing.		

Event ID: 7KD011

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/22/2023 1 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED
		345236	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORD	ACCORDIUS HEALTH AT WILMINGTON			-			
				vv	/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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	Continued From page	≥ 28	F	689	Staff Development Coordinator on the Smoking Binder, to go outside with the residents to the designated smoking a when observing smoking, and to secu all smoking paraphernalia after each smoke break. Indicate how the facility plans to monit its performance to make sure that solutions are sustained: Three times weekly for twelve weeks a various times the Director of Nursing, Assistant Director of Nursing, Unit Manager or Staff Development Coordinator will complete an audit to ensure the residents' smoking assessments are up to date, smoking materials are secured. The Departme Heads including the Nursing Home Administrator, Director of Nursing, Unit Manager, Staff Development Coordina Business Office Manager, Social Work Activities Director, Maintenance Direct Medical Record Coordinator and Housekeeper Director will perform random observation audits weekly for twelve weeks to validate residents are receiving the appropriate supervision based on the information in Smoking Binder, that the Smoking Monitor is outside with the residents to the designated smoking area when observ smoking and that smoking parapherna is being collected at the end of the sm break.	e rea re or at t t ator, ker, ior, ving	

Event ID: 7KD011

Facility ID: 923408

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/22/2 FORM APPRON OMB NO: 0938-0
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345236	B. WING		01/20/2023
NAME OF P	ROVIDER OR SUPPLIER			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 C X (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLETI D THE APPROPRIATE DATE
F 689	Continued From page	29	F	589 The Administrator or Direwill report the results of the Quality Assurance Perform Improvement Committee make changes to the plare assure compliance is sus	ne audits to the mance monthly and n as necessary to
F 727 SS=F	§483.35(b) Registere §483.35(b)(1) Except paragraph (e) or (f) of must use the services least 8 consecutive he §483.35(b)(2) Except paragraph (e) or (f) of must designate a regi director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa	(3) d nurse when waived under this section, the facility of a registered nurse for at purs a day, 7 days a week. when waived under this section, the facility stered nurse to serve as the	F 7		2/20/23
	Based on record revi facility failed to have a scheduled for 8 conse 92 days (09/02/22 an nurse staffing. This d potential to affect all f Findings Included: Review of the facility's from 07/01/22 through	ew and staff interviews the a registered nurse (RN) ecutive hours a day for 2 of d 09/12/22) reviewed for leficient practice had the acility residents.		 F727 POC Address how corrective a accomplished for those rehave been affected by the practice. The facility currently has a eight Registered Nurse he Address how the facility w residents having the pote affected by the same defined in the Residents residing in the residents residing in the residents residing in the residents residents residents in the residents resident in the residen	esidents found to e deficient a minimum of ours per day. vill identify other ntial to be cient practice:

Facility ID: 923408

If continuation sheet Page 30 of 78

ID PLAN OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	. ,	3	COMPLETED	
				С		
		345236	B. WING		01/20/2023	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 820 WELLINGTON AVENUE WILMINGTON, NC 28401		
ACCORDI	US HEALTH AT WILMING	GTON				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	
F 727	Continued From page	e 30	F 72	7		
				potential to be affected.		
		ducted with the Nursing		Address what measures will be put		
		at 2:10 PM. The Nursing		place or systemic changes made to		
		she was put in charge of		ensure that the deficient practice w	ill not	
	-	ormer Director of Nursing 2022. She further stated		recur:		
		ne facility had not had a		On February 10, 2023, the Schedu	ler was	
		he building for 8 consecutive		educated by the Nursing Home		
		y, but she was unable to		Administrator to ensure a Register	ed	
	recall which days. The	e Nursing Scheduler		Nurse is scheduled eight consecut	ive	
		lity's nursing staffing was		hours daily.		
	provided by 80% age	ncy staff.		Indicate how the facility plans to m	onitor	
	An interview was son	ducted with the		its performance to make sure that solutions are sustained:		
	An interview was con-	Regional Vice President of		solutions are sustained.		
	Operations on 1/12/23	-		Weekly for twelve weeks the Nursi	na	
	•	hat he expected the facility		Home Administrator (NHA), Directo	-	
	to have a RN in the b			Nursing (DON) or Assistant Directo		
	required 8 hours a da	iy every day.		Nursing (ADON) will audit the nurs	•	
				schedule and actual hours worked		
				validate eight consecutive hours of		
				Registered Nurse coverage per da		
				Results of the audits will be present the NHA or DON in the monthly Qu		
				Assurance and Performance	lailty	
				Improvement (QAPI) Meeting mon	thly for	
				three months. The QAPI Committe	-	
				review the audits and make		
				recommendations to assure compl	iance is	
				sustained ongoing.		
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1)-		F 73	2	2/20/23	
	§483.35(g) Nurse Sta					
		equirements. The facility				
	must post the followin basis:	ng information on a daily				
	(i) Facility name.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345236	B. WING			C 01/20/2023			
NAME OF P	ROVIDER OR SUPPLIER	L	-	STREET ADDRESS, CITY, STATE, ZIP CODE					
ACCORDI	ACCORDIUS HEALTH AT WILMINGTON			8	20 WELLINGTON AVENUE				
				v	VILMINGTON, NC 28401				
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE		
F 732	by the following categores in the following cate	and the actual hours worked aff directly responsible for t: s. I nurses or licensed defined under State law). des. g requirements. ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows: le format. access to posted nurse cility must, upon oral or e nurse staffing data c for review at a cost not to ty standard.	F	732	F732 POC Address how corrective action will be accomplished for those residents found have been affected by the deficient practice.	d to			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		345236	B. WING		01/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	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 PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	DATE
F 732	Continued From page	32	F 7	32	
	 F 732 Continued From page 32 the regulatory timeframe of 18 months for 6 of 18 months reviewed for staffing (08/22, 09/22, 10/22, 11/22, 12/22, 01/23). The findings included: 1. Review of the facility daily nurse staffing forms 			Accurate and complete is currently posted in the facility is currently utilizi staffing forms daily. Th are currently being secu for the regulatory timefr	e facility. The ng and posting the e staffing forms ured in the facility
	for the week of the surrevealed there were r hours listed on the da 01/09/23.	nrvey 01/09/23 -01/13/23 no registered nurse (RN) illy staffing form for		Address how the facility residents having the po affected by the same de	tential to be ficient practice:
	Scheduler on 01/12/2 Scheduler stated ther registered nurse (RN)	ducted with the Nursing 3 at 3:00 P.M. The Nursing e were no hours listed in the) column on the daily staffing		Residents residing in th been identified as havin be affected.	g the potential to
	working on the unit th in the building such a (DON), Assistant Dire	ause there was not an RN at day but there were RNs s the Director of Nursing ector of Nursing (ADON), pordinator (SDC) and the IDS) Nurse.		Address what measures place or systemic chang ensure that the deficien recur: On 2/10/23 the Adminis	ges made to t practice will not
	forms for 63 days of 7 An interview was com	able to provide daily staffing 73 days (11/01/22-01/02/23). pleted with the Director of ne Assistant Director of		education to the Staffing having accurate and co staffing data, posting th securing the forms for 1	mplete nurse e forms daily and
	DON stated that the f staffing forms and has she started working a	1/12/23 at 3:04 P.M. The acility did not have the daily d not been using them since t the facility in November		Indicate how the facility its performance to make solutions are sustained:	e sure that
	posting the daily staff the new Administrator facility.	ted that the facility started ing forms last week when r began working at the		The Administrator, Direct Staff Development Coo Assistant Director of Nu observational audits twi weeks to validate accur	rdinator or Irsing will conduct ce a week for 12 ate and complete
		able to provide the daily last 6 months reviewed for , 10/22, 11/22, 12/22,		nurse staffing data, pos daily and securing the f months. Results of the audits will be presented	orms for 18 observational

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If continuation sheet Page 33 of 78

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	(X3) DATE S	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	:TED
		345236	B. WING		C 01/20/2023	
NAME OF P	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 732 F 755 SS=E	An interview was con Administrator and the Operations on 01/12/ Administrator stated to using the CMS daily s when he started work stated that the Daily s accurate and posted Regional Vice Presid that the facility would for the required time Pharmacy Srvcs/Proc	ducted with the e Regional Vice President of 23 at 4:15 P.M. The that the facility had not been staffing form until 01/02/23 king at the facility. He further Staffing Form should be in the front lobby. The ent of Operations indicated save the daily staffing forms frame of 18 months. cedures/Pharmacist/Records	F 732	Administrator in the monthly Qua Assurance Performance Improve (QAPI) meeting monthly for three The QAPI committee will review to observational audits and make recommendations based on findi assure compliance is sustained of	ment e months. the ngs to ongoing.	2/20/23
	drugs and biologicals them under an agree §483.70(g). The facil personnel to adminis permits, but only und a licensed nurse. §483.45(a) Procedure pharmaceutical servio that assure the accur dispensing, and admi biologicals) to meet th	ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and he needs of each resident.				
	must employ or obtai pharmacist who- §483.45(b)(1) Provide	onsultation. The facility n the services of a licensed es consultation on all ion of pharmacy services in				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/22/202 FORM APPROVEI OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
		345236	B. WING		C 01/20/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH AT WILMINGTON			820 WELLINGTON AVENUE WILMINGTON, NC 28401			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 755	receipt and disposition sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acco is maintained and per This REQUIREMENT by: Based on observation interviews, Pharmacy Practitioner and Physithe facility failed to for were not available front to follow the pharmaco receiving medications (Resident #22 and #1 Findings included: 1. Resident #22 was 08/29/16. Diagnoses disorder, bipolar diso allergies, and gastroe (GERD). A review of the physic 08/22/18 an order for milligrams (mg) one of day for GERD, an ord Valproic Acid Solution give 625 mg by mout schizoaffective disord 06/22/21 for Cetirizin- daily for allergies. The Minimum Data S	 an of all controlled drugs in able an accurate able an accurate able	F 75	 5 F755 POC Address how corrective action will accomplished for those residents have been affected by the deficien practice: Resident #22 and Resident #14 a currently receiving their medicatio physician's order. Address how the facility will identi residents having the potential to b affected by the same deficient practice been identified as having the pote be affected. On 2/9/23 the Director of Nursing, and Manager conducted a house-wide baseline audit to compare the Me Administration Record to medicati hand for each resident to assure a resident had medication readily avper physician order. Any medicati was not readily available was record and the attending physician or physician or	found to nt ire ons per ify other be actice : in have ential to , I Unit e dication ions on each vailable on that ordered ysician's orders. If	

Facility ID: 923408

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345236	B. WING _		C 01/20/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
				82	20 WELLINGTON AVENUE		
ACCORD	US HEALTH AT WILMING	STON			ILMINGTON, NC 28401		
(X4) ID PREFIX TAG			ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	 755 Continued From page 35 demonstrated no behaviors, and received 7 days of an antipsychotic medication during this look back period. The Medication Administration Record (MAR) review for Resident #22 revealed: " 01/02/23, 01/03/23, 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23, and 01/10/23 the Valproic Acid Solution order for 625 mg had the #9 recorded for the 9:00 AM dose on 01/02/23, and 01/03/23 and the #9 recorded for both doses (9:00 AM and 9:00 PM on 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23 and 01/10/23. " 01/08/23 and 01/11/23 the order for Cetirizine 10 mg had the #9 recorded and on 01/08/23, 01/09/23 and 01/11/23 the MAR revealed the order for Prilosec 20 mg had the #9 recorded. 		F	755	completed. Address what measures will be put into	D	
					place or systemic changes made to ensure that the deficient practice will n recur:		
					Weekly on Thursdays going forward th Director of Nursing, Assistant Director Nursing, Staff Development Coordinate Unit Manager, or Nurse Supervisor in Charge will audit each medication cart and re-order medications, if indicated. Director of Nursing, Assistant Director Nursing, Staff Development Coordinate Unit Manager, or Nurse Supervisor in Charge will use Polaris Connect Pharmacy System to reorder medication	of or, The of or,	
	the #9 meant to "see A review of the electro administration notes f 01/02/23 revealed:	onic medication			The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge initiated education to each Licensed Nurse on contacting the pharmacy to have back pharmacy send any medication that is available and to contact the Nurse	not	
	on pharmacy," On 01 note indicated the Val order," and on 01/08/. Valproic Acid Solution were no medication n 01/09/23, or 01/10/23 Acid Solution was not " 01/08/23, the me Cetirizine 10 mg was 01/11/23 the note indi pharmacy."	dication note indicated the "out of stock," and on			Manager on call. Any Licensed Nurse did not receive the education by 2/20/2 will not be permitted to work and will receive the education prior to the start their next scheduled shift. No Licensed Nurse will be permitted to work after 2/20/23 without receiving the education The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided education to each Licensed Nurse and Certified Medication Aid on actions to t	23 of I n.	

Facility ID: 923408

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
						С
		345236	B. WING		0	1/20/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		CTON		820 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMIN	GION		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 755	Continued From pag	e 36	F 75	55		
		was "out of stock," and on	170	if a medication is not readily av	ailable on	
	01/11/23 the note ind	-		2/20/23. Certified Medication A		
		as no medication note		notify the Licensed Nurse if a n		
		ilosec was not given on		is unavailable. Licensed Nures		
	01/09/23.	-		the Physician or Physician's Ex	tender for	
				further orders if a medication is		
		e medication storage room		unavailable. Any Licensed Nur		
		AM revealed there was no		Medication Aid who did not rec		
		osec or Cetirizine. The		education by 2/20/23 will not be		
	-	oom was noted to have a		to work and will receive the edu		
	medication dispensin	ig machine.		prior to the start of their next so shift. No Licensed Nurse or Ce		
	An observation of the	e medication cart on 01/13/23		Medication Aid will be permitted		
		there was a bottle of		after 2/20/23 without receiving		
	-	n for Resident #22 with a		education.		
		ne order date was 01/06/23				
	and an opened date			Any newly hired License Nurse	and newly	
	•			hired Certified Medication Aid v	vill receive	
	An interview was cor	nducted with Medication Aide		the education from the Staff De	velopment	
		at 8:40 AM. She stated on		Coordinator, Director of Nursing	g, Unit	
		ented the #9 which meant		Manager, or Nurse Supervisor	-	
		the Valproic Acid Solution		on medication reordering to en		
		ause it was not available and		medication is available and act		
		he point click care (PCC)		if a medication is not readily av		
		c system that was connected		during their classroom orientati	on, prior to	
		eordering and receiving w it had been ordered so she		provision of care.		
		pharmacy" in the nurses'		Any agency License Nurse or a	adency	
	-	he believed she told Nurse		Certified Medication Aid will rec		
		ble on 01/02/23. MA #2		education from the Staff Develo		
		was not available on the		Coordinator, Director of Nursin		
	medication cart on 0	1/11/23, so she documented		Manager, or Nurse Supervisor		
		ince the Cetirizine was not		on medication reordering to en		
		he medication storage room		medication is available and act		
		ntacting pharmacy" because		if a medication is not readily av	ailable,	
		he PCC system, she noticed		prior to provision of care.		
		dered on 12/29/22. She				
		ow when the medication		Indicate how the facility plans t		
	would arrive, and she	e would check with her nurse		its performance to make sure the	nat	

Facility ID: 923408

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		MEDICAID SERVICES					D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	E SURVEY PLETED
		345236	B. WING			С	
		545256				01	/20/2023
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMING	GTON			0 WELLINGTON AVENUE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO
F 755	Continued From page	e 37	F 75	55			
		acy. MA #2 stated she			solutions are sustained:		
		ion was not available on her			Five times weekly for twelve weeks the	2	
		ion storage room, so she			Director of Nursing, Assistant Director		
		k" on the medication note.			Nursing, Unit Manager, or Nurse		
	MA #2 stated she told	Nurse #10 the medication			Supervisor in Charge will randomly		
	was not available.				observe ten residents' medication		
					administration pass to validate		
		se #10 on 01/11/23 at 3:30			medications are available to be		
		ld not recall if she was made			administered per order or that the		
	-	1/02/23 that the Valproic			physician was notified for further orders	S.	
		t available for Resident #22, d MA #2 did not inform her			During the auditing, if it is noted that a medication is not available and the		
		Prilosec medications were			process was not followed, the Licensed	4	
		re not given to Resident #22			Nurse or Medication Aid will be remove		
		10 stated she would notify			from patient care and a one-to-one	-	
	the physician.	, ,			educational in-service will be provided	by	
					the Director of Nursing or Staff		
	An interview was con	ducted with the Unit			Development Coordinator. The License	ed	
	J U ()	/11/23 at 3:10 PM. She			Nurse will not be permitted to provide		
		Prilosec were house stock			patient care until they can correctly sta		
	-	C) medications so they			the facility's process when medication	is	
	would not be in the m				not available. Each Thursday for 12		
	machine, but they wo				weeks, the Director of Nursing, Assista		
	PCC electronic system	oom. The UM reviewed the			Director of Nursing, Staff Development Coordinator, Unit Manager, or Nurse	L	
		was reordered on 12/29/22.			Supervisor in Charge will document that	at	
	The UM added, that s				each medication cart was audited, and		
		lication, it should not have			medications were re-order, if indicated.		
		PCC system and even			The Director of Nursing, Assistant		
		ed that way, we would not			Director of Nursing, Staff Development	t	
		edication from the pharmacy			Coordinator, Unit Manager, or Nurse		
		deliver over the counter			Supervisor in Charge will use Polaris		
		the PCC system. She			Connect Pharmacy System to reorder		
		cations were ordered by her			medications. Additionally, twice daily for		
		ly company and added that			four weeks, a house wide observationa	al	
		e medication needed to be			audit of the Electronic Medical Record		
	list. She stated the N	added to her direct supply			Dashboard will be performed by the Director of Nursing, Assistant Director		

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		MEDICAID SERVICES	(X2) MI II TIDI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345236	B. WING		01/20/2023
NAME OF PI	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 755	Continued From page	e 38	F 755	5	
F 755	let the nurse or her ku her cart and we could ordered for the reside Prilosec OTC medica and she had a recent meant the Prilosec sh medication carts. Sh and Nurses have been notify the Unit Manag not have the prescrib was not acceptable to following up on where UM explained that wh that the pharmacy pro- go into PCC, select th Once you hit reorder, electronically with the when the medication the nurse receiving th to go back into PCC to received. The UM stat "received" it will mess stated she has had in regarding this process the way they are sup causing delays with r A phone interview wa Pharmacy Supervision The Pharmacy Supervision The	now it was not available on d have gotten the medication ent. The UM added that the ation was ordered 11/27/22 - t order for 01/06/23 which hould be available on the ne stated Medication Aides en educated to be sure they ger or Pharmacy if they do need medications and that it o keep recording #9 and not e the medications were. The nen ordering medications ovided, the process was to he medication, hit reorder. , it communicated e pharmacy. The UM stated was delivered to the facility, ne medications would need to that reorder and select ated if you don't record s up future orders. She n services with the Nurses is, but they don't always do it posed to, and it has been eorders. as conducted with the r on 01/13/23 at 10:20 AM. rvisor stated the Valproic ident #22 was ordered on ed and signed for at the t 8:17 AM. The Pharmacy	F 758	Nursing, Unit Manager, or Nurse Supervisor in Charge to assure eac resident's medication is administer physician order. The audits will be presented by the Director of Nursin the facility's Quality Assurance and Performance Improvement Commit review monthly for three months. T facility's Quality Assurance and Performance Improvement Commit make recommendations as needed assure compliance is sustained on	ed per g to ttee for he ttee will I to

Facility ID: 923408

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/22/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345236	B. WING					C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COE	ЭE		
	US HEALTH AT WILMING	TON		8	20 WELLINGTON AVENUE			
ACCORDI	US REALTH AT WILMING			v	VILMINGTON, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
	Continued From page ordering medications the PCC system. On delivered and receive enter "received" in the they do not receive the come through accurat and it confuses the re- stated the pharmacy of order" and indicate "in the manifest; 2) they of which were provided which were provided which were connected electronically by scan label for reorders and remove the sticker fro- card/bottle and adher sheet and fax to the p An interview was com- 01/13/23 at 12:14 PM worked on the medica- to the Charge Nurse a stated if she did not s on the cart, she would document on the MAR the nurses notes why given and notify the c given. She stated on 01/10/23 she recorde Acid Solution for Resi because she did not s	e 39 for the facility: 1) Reorder in ce the medication was d, the nurse would need to e PCC system. She stated if e medication, it would not tely on the pharmacy side ordering system. She would then "kick back the ot ready to be reordered" on could use the scanner guns to all the nursing stations d to the pharmacy ning the bar code on the returns; or 3) they could on the medication e to a pharmacy reorder harmacy. ducted with MA #5 on . MA #5 reported when she ation cart, she would report assigned to that hall. She ee an ordered medication d reorder it on PCC, R the #9 and put a note in the medication was not harge nurse that it was not 01/03/23, 01/09/23, and d the #9 for the Valproic		755			ATE	DATE
	During this interview, bottle of Valproic Acid cart and confirmed it and opened on 01/11, recall any bottles of V	MA #5 identified the open Solution in the medication was received on 01/07/23 /23. She stated she did not alproic Acid Solution being						
	in the medication cart	on 01/03/23, 01/09/23 or						

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			()(0) 1 ····			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
			A. BUILDING	3		0
		245220	B. WING			С
		345236	B. WING			1/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE		
				WILMINGTON, NC 28401		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETIO DATE
F 755	Continued From pag	e 40	F 75	5		
		ted as far as she knew all				
		uding over the counter				
		dered through pharmacy by				
	using the PCC system					
A 0 ⁻ w de	5					
	An interview was cor	nducted with Nurse #11 on				
	01/13/23 at 12:47 PM	 Nurse #11 confirmed she 				
	worked on 01/06/23	and 01/10/23 and				
	documented the #9 d	on the MAR for the Valproic				
	Acid Solution for Res	ident #22. She stated she				
	should have put a nu	rses note in the electronic				
		ndicate why it was not given				
	on those days. She	stated she could not recall if				
	MA #5 notified her or	01/03/23 that the Valproic				
	Acid Solution was no	t available to be given. She				
	stated on 01/06/23 a	nd 01/09/23 she checked the				
	medication storage r	oom but there was none in				
	there. During this int	erview, Nurse #11 reviewed				
	the medication cart a	nd confirmed the bottle of				
	Valproic Acid Solution	n for Resident #22 was in the				
	medication draw and	had been ordered on				
	01/06/23 and deliver	ed on 01/07/23 with an				
	opened date on 01/1	1/23. She stated she could				
		s not given on 01/08/23 and				
		n delivered on the 01/07/23.				
		AR and saw that that the				
		given for both doses on				
		"it must have been in the cart				
	-	01/07/23. She stated there				
		oblems with reordering on				
		miss because some nurses				
		n, and some did not. She				
		e the PCC system to reorder				
		Ild just fax the orders, but				
	when she received n					
		I check to see if any of the				
	medications were in	PCC and needed to be				
		ed if the reorder was done in				

Facility ID: 923408

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DEPARTMENT OF HE CENTERS FOR MEDI		D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/22/2023 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING				C 20/2023
NAME OF PROVIDER OR SUP	PPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH A	- WIL MINIC	TON		8	20 WELLINGTON AVENUE		
ACCORDIUS HEALTH A				v	VILMINGTON, NC 28401		
PREFIX (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
always gettii could not rea Aides that th given to Res 01/05/23 wh those days. Prilosec 20 of being plenty stated she of #2 did not ac Nurse #3 sta Physician bo station that th and Resider An interview Practitioner NP stated R Solution to th stated she w receiving the #22 to have potential for stated she w received her interview, th for January 3 documentati receiving stated she m assessed R had her bas not receiving stated she m	n PCC ar ng done. call being be Valproi sident #22 en she w She state mg on 01 available ould not e dminister ated she k book which the medicat was con (NP) on 0 esident # reat schiz vas not av e medicat breakthro negative vas not av cetirizin e physicia 2023 and on to indi y of these esident # 2023 and on to indi y of these esident # cetirizin e physicia 2023 and on to indi y of these esident # She state	ad she was not sure that was Nurse #11 reported she notified by the Medication c Acid Solution was not 2 on 01/03/23, 01/04/2, or as the Charge Nurse on ed she administered the (10/23 and recalled their for administration. She explain why MA #5 and MA it on 01/08/23 and 01/11/23. believed she noted in the was kept at the nursing ations were not available, not receive them. ducted with the Nurse (1/13/22 at 1:10 PM. The 22 was getting Valproic Acid oaffective disorder. She vare the resident was not ion as ordered and that not ion could cause Resident ough symptoms with the side effects. The NP also vare Resident #22 had not e or Prilosec. During this an notebook was reviewed there was no cate Resident #22 had not medications. The NP 22 and reported she was had no adverse effects from ications as ordered. She he medical records and g staff, and she has had no a result of not receiving the ed knowing this she would	F	755			

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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 20/2023
NAME OF PF	ROVIDER OR SUPPLIER	L	I	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMING	GTON			320 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 755	Continued From page	e 42 h the Physician Assistant	F	755			
	(PA) on 01/13/23 at 3 the first time she was not receiving her Valp	:50 PM revealed this was hearing about Resident #22 proic Acid, Prilosec, or					
	to be notified after mis	d she would have expected ssing 1 and no more than 2 and Cetirizine, but she					
		b have been notified if she es of the Valproic Acid.She as a history of					
	could have caused he	ler and missing those doses er to become unbalanced.					
		and medication aides were ion "not available," she					
	would expect them to	be following up on the ure it was available and to					
	President on 01/13/23	Regional Clinical Vice 3 at 4:55 PM revealed there					
	was a systems proble receiving medications Charge Nurse when a	s as well as notifying the					
	available. She stated	l she would expect nursing sidents were receiving their					
	Medication Aides wer	e notifying the Charge dications were not available.					
	09/03/13 with diagnos	s admitted to the facility on sis to include high blood y artery disease, and high					
	was written on 05/12/ 10 mg; one tablet dail	an's order revealed an order 22 for Atorvastatin Calcium ly for high cholesterol and on Lisinopril tablet 2.5 mg; give					

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					FORM	APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COMF	SURVEY PLETED
	345236	B. WING				C 20/2023
PPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	GTON					
I DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE
laily for his he Medica anuary 20 umented 1 h. The Lis ter "X" rea 01/07/23 a lood press hich mean he electro 12 on 01/07 was "not 01/07/23 a Lisinopril Resident # 01/06/23 on 01/08/ /hg. Ther 01/07/23 a tion of the it Manage ng and Ata erview wit 3 at 10:20 Lisinopril 2 ad it was r She stated 2 and there being rem unit. The tatin was 1 n 01/09/23	gh blood pressure. ation Administration Record D23 revealed on 01/03/23 the by Nurse #12 for the inopril order was noted to corded on 01/06/23 by MA and 01/08/23 by MA #6 sure with the #9 and #5 at to see nurses' notes. nic medication nursing notes D3/23, the note stated available," and on 01/06/23 and 01/08/23 by MA #6 the "not available." E14's blood pressure at was recorded as 142/88 /23 the blood pressure was e were no blood pressure at medication dispensing cart or on 01/13/23 revealed browstatin 10 mg were both th the Pharmacy Supervisor AM revealed the pharmacy 2.5 mg on the evening of the eceived on the morning of a the Lisinopril was last filled e was no record of the noved from the medication Pharmacy Supervisor stated last filled on 01/08/23 and B at 8:39 AM. She stated	F	755	5		
	ICARE & S IPPLIER AT WILMING UMMARY ST I DEFICIENC LATORY OR From page daily for high he Medica lanuary 20 cumented I n. The Liss ther "X" req 01/07/23 a lood press hich mear he electron 12 on 01/0 n was "not 01/07/23 a Lisinopril Resident # n 01/06/23 on 01/08/ /hg. Ther n 01/07/23 a Lisinopril Resident # n 01/07/23 at 10:20 Lisinopril 2 She stated 2 and there being rem unit. The tatin was In 01/09/23	identification number: 345236	ICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: (X2) MUL IDENTIFICATION NUMBER: (X2) MUL ALBUILD 345236 B. WING IPPLIER ID PREF AT WILMINGTON ID PREF From page 43 F ID faily for high blood pressure. he Medication Administration Record Ialanuary 2023 revealed on 01/03/23 the sumented by Nurse #12 for the F numented by Nurse #12 for the The Lisinopril order was noted to tter "X" recorded on 01/06/23 by MA 46 1000 pressure with the #9 and #5 hich meant to see nurses' notes. he electronic medication nursing notes 12 on 01/03/23, the note stated 10/06/23 10/07/23 and 01/08/23 by MA #6 the Lisinopril "not available." Resident #14's blood pressure n01/06/23 it was recorded as 142/88 on 01/08/23 the blood pressure was /ng. There were no blood pressure on 01/07/23. at 10:20 AM revealed the pharmacy Lisinopril 2.5 mg on the evening of the nd it was received on the morning of She stated the Lisinopril was last filled 2 and there was no record of the being removed from the m	ICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI IDENTIFICATION NUMBER: A BUILDING JPPLIER JA45236 B. WING	ICARE & MEDICAID SERVICES s (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BULDING IPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 20 WELLINGTON AVENUE WILMINGTON NC 28401 UMMARY STATEMENT OF DEFIDENCIES DEPICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRI (EACH CORRECTIVE ACTION SHOLLD CROSS-REFERENCED TO THE APPROPRI DEFIDIENCY) From page 43 taily for high blood pressure. F 755 he Medication Administration Record lanuary 2023 revealed on 01/03/23 the umented by Nurse #12 for the 1. The Lisinopril order was noted to ther "X" recorded on 01/06/23 by MA 01/07/23 and 01/08/23 by MA #6 lood pressure with the #9 and #5 hich meant to see nurses' notes. he electronic medication nursing notes 12 on 01/03/23, the note stated 10 was "not available," vass "not available," Preview with the Pharmacy Supervisor 3 at 10:20 AM revealed the pharmacy Lisinopril "not available." review with the Pharmacy Supervisor 3 at 10:20 AM revealed the pharmacy Lisinopril 2.5 mg on the evening of the dng and Atorvastatin 10 mg were both erview with the Pharmacy Supervisor 3 at 10:20 AM revealed the pharmacy Lisinopril 2.5 mg on the evening of the being removed from the medication unit. The Pharmacy Supervisor stated tatin was last filled on 01/08/23 and no 10/08/23 and no 1	ICARE & MEDICAID SERVICES OMB NC s (x1) PROVDERSUPPLERCIAL IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILING (x3) DATE CONSTRUCTION JPPLER 345236 IV WIG (01) IPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 220 WELLINGTON, NC 28401 (01) IVUMININGTON STREET ADDRESS, CITY, STATE, ZIP CODE 220 WELLINGTON, NC 28401 (01) IVUMININGTON IPPOTORES FLANGE COPERCINCUM (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE DEFICIENCY WIGT BE PRECIDED BY FULL AT GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY IPPOTORES FLANGE CORRECTION (RAD OR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) From page 43 F 755 faily for high blood pressure. F 755 he Medication Administration Record fanuary 2023 revealed on 01/08/23 by MA #6 flood pressure with the #9 and #5 hinch meant to see nurses' notes. F 755 he electronic medication nursing notes 12 on 01/08/23 by MA #6 the Lisinopril "not available." IPPOTORES FLOOD FOR SURE 001/08/23 the blood pressure 001/08/23 it was recorded as 142/88 on 001/08/23 the blood pressure 001/08/23 it was recorded as 142/88 roy 001/08/23 the blood pressure was //g. There were no blood pressure 001/08/23 the blood pressure was //g. There were no blood pressure 001/08/23 the blood pressure was //g. There were no blood pressure 001/08/23 the stated the blood pressure 001/08/23 the stated the blood pressure was //g. There were no blood pressure 001/08/23 the as fulled on 01/08/23 and no 01/08/23 the as fulled in the medication unit. The Pharmacy Supervisor stated tatin was last filled on 01/0

Facility ID: 923408

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345236	B. WING				C /20/2023
NAME OF P	ROVIDER OR SUPPLIER		- I	:	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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	removed from the me The Pharmacy Super should not have need we provided a 30-day therefore, on 01/03/23 tablets left. The Phar Resident #14 missing medication, it could ca increased blood press the resident would no dose. An interview with Med 01/11/23 revealed the so she documented the available." She stated was ordered or when puts the #9. MA #4 s access to the medicar nurse would have to g not remember if she t 01/06/23. Medication Aide #6 w on the MAR on 01/07 available for an interv Nurse #12 who record Atorvastatin on 01/03 interview. An interview with Nurse PM revealed the Ator were both available ir unit and if the Medica her know there was n she would have remo medication dispensing	dication dispensing unit. visor stated the facility led the Atorvastatin because r supply on 12/10/22 3 they should have had 7 macy Supervisor stated with 3 days of Lisinopril ause the resident to have an sure, but it was not likely that tice it as it was a very mild dication Aide (MA) #4 on a Lisinopril was not available he #9 on the MAR "not d she did not know when it it was coming in, so she just tated she did not have tion dispensing unit and the get it. She stated she could old the nurse or not on ho recorded the #5 and #9 /23 and 01/08/23 was not iew. ded the #9 for the /23 was not available for an se #11 on 01/13/23 at 12:47 vastatin and the Lisinopril o the medication dispensing tion Aide came to her to let one available on the cart,	F	755	5		

Facility ID: 923408

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	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345236	B. WING			C 1/20/2023
	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP COD		1/20/2023
				WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMIN	GTON	w	LMINGTON, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	Resident #14. A phone interview wa Physician Assistant (The PA stated she w #14 had not received stated if nurses and in documenting medical would expect them to medication to make a notify her for addition stated given that the was not likely that it w blood pressure with the	e 45 ations not being available for as conducted with the (PA) on 01/13/23 at 3:50 PM. as not made aware Resident these medications. She medication aides were tion "not available," she b be following up on the sure it was available and to hal orders if needed. The PA Lisinopril was a low dose it would affect the resident's 3 doses being missed.	F 755			
	Charge Nurse when available. She stated staff to be sure the re prescribed medicatio Medication Aides we Nurses when the me Drug Regimen Revie CFR(s): 483.45(c)(1) §483.45(c) Drug Reg §483.45(c)(1) The dr must be reviewed at licensed pharmacist.	s as well as notifying the a medication was not d she would expect nursing esidents were receiving their ons and to make sure re notifying the Charge dications were not available. ew, Report Irregular, Act On 1(2)(4)(5) gimen Review. ug regimen of each resident least once a month by a	F 756			2/20/23

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345236	B. WING _				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILMING	TON		82	20 WELLINGTON AVENUE		
ACCORD	US REALTH AT WILMING	STON		N	/ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 756	irregularities to the att facility's medical direct and these reports mut- (i) Irregularities included drug that meets the cal (d) of this section for a (ii) Any irregularities in during this review mut- separate, written repor- attending physician and director and director of minimum, the residen and the irregularity the (iii) The attending phy- resident's medical reor irregularity has been taken be no change in the n- physician should door the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review f limited to, time frames the process and steps when he or she identi requires urgent action This REQUIREMENT by: Based on record revi Pharmacist Consultar Assistant interviews th the Pharmacist's reco- monthly Consultant P Regimen Review for	rending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist st be documented on a ort that is sent to the and the facility's medical of nursing and lists, at a t's name, the relevant drug, e pharmacist identified. reviewed and what, if any, n to address it. If there is to nedication, the attending ument his or her rationale in record.	F7	756	F 756 POC Resident Affected: Resident #24 as needed order for Clonazepam was discontinued per physician's order on 1/13/2023. Residents with Potential to be Affected		

Facility ID: 923408

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/22/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE : COMPL	ETED
		345236	B. WING			-	, 20/2023
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
	US HEALTH AT WILMING	STON		8	20 WELLINGTON AVENUE		
ACCORDI	US REALTH AT WILMING	JION		v	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 756	Continued From page	e 47	F	756			
	Resident #24 was ad 11/02/22. Diagnoses disorder, bipolar disor A physician's order w Clonazepam (medica milligrams. Give one hours as needed for a include a 14-day limit have a stop date of 1 place until 01/11/23. The Minimum Data S assessment dated 11 #24 was cognitively in behaviors and receive antidepressant and 5 pain medication). Sh receiving any antianx review period. During a medication r Consultant Pharmacia 11/27/22 revealed Re needed (PRN) order for Clonazepam 0.5 mg, greater than 14 days recommendation was discontinuing the PRI rationale for extended specific duration. Re recommendation was	mitted to the facility on included major depressive rder, and anxiety disorder. as written on 11/02/22 for tion to treat anxiety) 0.5 tablet by mouth every 12 anxiety. The order did not ed duration which would 1/16/22. This order was in et 5-day admission /07/22 revealed Resident ntact, demonstrated no ed 6 days of an days of opioids (narcotic e was not coded as iety medications during this regimen review, a st recommendation dated esident #24 had an as for a psychotropic drug, which had been in place for without a stop date. The a to consider either (1) N order, or (2) provide d time period and indicate a cord review revealed the a not acted upon. The facility de a signed MMR from the			Effective February13, 2023 the Director Nursing, Assistant Director of Nursing and Unit Manager conducted a 100% audit of all residents on as needed psychotropic medications to ensure th was an appropriate stop date and con the physician or physician's extender of further orders if needed or ensure a rationale and duration for continued us documented. On February13, 2023 the Director of Nursing conducted an audi Consulting Pharmacist Recommendate for the past three months. Those residents identified as not having time follow-up were reviewed by the Physic with further orders, if any, implemente Systematic Changes: On 1/23/23 the Regional Vice Preside Clinical Services educated the Nurse Management Leaders (Director of Nursing, Assistant Director of Nursing and Unit Manager) on reviewing and providing to the attending physician or physician extender the pharmacy recommendations. The Staff Development Coordinator, Director of Nursing or Nursing Supervisor educate Licensed Nurses when receiving physician or physician extender orders obtain a 14-day stop date for all psychotropic medications prescribed of an as needed basis or to ensure a	, ere tact for se is e t of ions ly sian d. nt of ,	
	The December MRR' reviewed and there w	s were requested and /as no recommendation epam 0.5 milligram order for			rationale and duration for continued us documented. The Director of Nursing be responsible for ensuring pharmacy recommendations are communicated	will	
	7(02-99) Previous Versions Obs				cility ID: 923408		

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		MEDICAID SERVICES				NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		ATE SURVEY OMPLETED
	OURICEO HON	DENTIFICATION NUMBER.	A. BUILDING			
						С
		345236				01/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE		
ACCORDI				WILMINGTON, NC 28401		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From page	e 48	F 75	6		
	Resident #24.			the physician or physician	extender and	
				follow-up recommendation		
	An interview with the	Director of Nursing (DON)		implemented by the Nurse		
		PM. The DON stated the		Leaders. After 2/20/23 no l		
	pharmacy medicatior	n regimen reviews were done		Nurses will be permitted to	work without	
	monthly and submitte	ed to the DON via email by		receiving the aforemention	ed education	
	the Pharmacist Cons	ultant. She stated when she		from the Director of Nursing	g, Staff	
	received the recomm	endations, she printed them		Development Coordinator,	Assistant	
	off and gave them to	the Assistant Director of		Director of Nursing, or Nurs	se Supervisor.	
	Nursing to manage.					
				Newly hired licensed nurse	es and agency	
	An interview with the	Assistant Director of Nursing		nurses will receive education	on, prior to	
	(ADON) on 01/11/23	at 4:45 PM revealed she had		working or as part of the ne	ew hire	
	placed the pharmacy	recommendations in the		orientation, by the Staff De	velopment	
	Physician and Physic	cian Assistant's box in their		Coordinator or Nursing Sup	pervisor on	
	office to review and s	sign. The ADON stated she		obtaining a 14-day stop da	te for all	
	recalled the providers	s signing them and returning		psychotropic medications p	prescribed on	
	the recommendations	s to her for the month of		an as needed basis or ens	ure a rationale	
	November, but she c	ould not find them. She		and duration for continued	use is	
	stated her process w	as when she received the		documented.		
	recommendations ba	ck from the providers she				
		plement any new orders they		Monitoring:		
	had indicated on the	recommendation and put a				
		commendation, so she		The Director of Nursing or	-	
		l, but she was unable to find		will conduct audits of ten re		
	•	ned recommendations from		needed psychotropic medie		
	November.			for 14-day stop dates or rat		
				duration for continued use		
		Physician 01/12/23 at 12:10		Monitoring will be complete		
		not received the pharmacy		three months and as neces	-	
		d if had he would have		thereafter. The Consultant		
		mendation and signed it.		Recommendation to be au		
	The Physician stated			completion by the Director		
	Clonazepam order sh			each month for three month		
		days since it was an as		Administrator or Director of		
		r a rationale should have		report the audit findings to		
	been provided to con	unue the medication.		Assurance Performance In		
	An interview with the			Committee monthly for a m three months. The Quality		

Facility ID: 923408

If continuation sheet Page 49 of 78

ATEMENT (S FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED C 01/20/2023	
		345236	B. WING			
IAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
CCORDI	US HEALTH AT WILMI	NGTON		20 WELLINGTON AVENUE VILMINGTON, NC 28401		
	SUMMADY					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLI	
F 756	Continued From pa	ge 49	F 756			
	-	/ I via phone stated she		Performance Improvement Comm	ittee will	
		bringing the pharmacy		make recommendations to the pla		
		o her back in November, and		necessary to assure compliance is	3	
		igned them and brought them		sustained ongoing.		
	back to the ADON and put them on her desk but could not recall specifically if one of them was for					
		N order for Clonazepam.				
	A phone interview v	vas conducted with the				
		cist on 01/18/23 at 11:27 AM.				
	-	armacist stated during her				
	-	cy reviews she did not see a				
	· ·	commendation from 11/27/22.				
		ad a note from her December ated 12/27/22 that the				
		r the Clonazepam order for				
		not acted upon and she				
		te MRR for the facility to				
	review the active re	commendation that was				
	lacking a final respo					
F 758 SS=D		sychotropic Meds/PRN Use 3)(e)(1)-(5)	F 758		2/20/2	
	§483.45(e) Psychot	tropic Drugs.				
	§483.45(c)(3) A psy	chotropic drug is any drug that				
		es associated with mental				
	· ·	avior. These drugs include,				
		o, drugs in the following				
	categories: (i) Anti-psychotic;					
	(ii) Anti-depressant;					
	(iii) Anti-anxiety; an					
	(iv) Hypnotic					
		hensive assessment of a				
	resident, the facility	must ensure that				
	1					

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	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I		(20) MU				0.0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP	LETED
			AL BOILDI	<u> </u>			C
		345236	B. WING				20/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILMING	STON	820 WELLINGTON AVENUE				
ACCORDI	05 HEALTH AT WILMING			v	VILMINGTON, NC 28401		
(X4) ID	-		ID		PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		DATE
					DEFICIENCY)		
F 758	Continued From page		F	758			
		e not given these drugs					
		n is necessary to treat a diagnosed and documented					
	in the clinical record;	diagnosed and documented					
	,						
		nts who use psychotropic					
		l dose reductions, and					
	behavioral interventio	effort to discontinue these					
	drugs;						
	§483.45(e)(3) Reside						
		ursuant to a PRN order n is necessary to treat a					
		In that is documented					
	in the clinical record;						
		rders for psychotropic drugs					
	-	 Except as provided in attending physician or 					
	prescribing practition						
		RN order to be extended					
		or she should document their					
		ent's medical record and					
	indicate the duration f	for the PRN order.					
	\$483.45(e)(5) PRN o	rders for anti-psychotic					
		4 days and cannot be					
	renewed unless the a						
		er evaluates the resident for					
	the appropriateness of This REQUIREMENT	is not met as evidenced					
	by:						
	Based on record revi	iew, staff interviews, Nurse			F 758 POC		
		macist Consultant interviews					
	-	isure an as needed (PRN)			Resident Affected:		
		ion (medications used to nd psychiatric symptoms)			Resident #24 as needed order for		
		s or document the continued			Clonazepam was discontinued per		

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/22/2 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345236	B. WING		01/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
F 758	Continued From page	• 51	F 758	3	
	use with a rationale a residents (Resident #	nd duration for 1 of 5		physician's order on 1/13/2023.	
	unnecessary medicat	•		Residents with Potential to be A	Affected:
	Findings included:			Effective February13, 2023 the Nursing, Assistant Director of N	lursing,
	11/02/22. Diagnoses	nitted to the facility on included major depressive der, and anxiety disorder.		and Unit Manager conducted a audit of all residents on as need psychotropic medications to ens	ded
		as written on 11/02/22 for		was an appropriate stop date at the physician or physician's exte	nd contact
	Clonazepam (medica	tion to treat anxiety) 0.5 tablet by mouth every 12		further orders if needed or ensured and duration for contin	ire a
	include a 14-day limit	anxiety. The order did not ed duration which would		documented. On February13, 2 Director of Nursing conducted a	an audit of
	have a stop date of 1 place until 01/11/23.	1/16/22. This order was in		Consulting Pharmacist Recomm for the past three months. Thos	e
	The Minimum Data S	et 5-day admission /07/22 revealed Resident		residents identified as not havin follow-up were reviewed by the with further orders, if any, imple	Physician
	#24 was cognitively in	itact, demonstrated no			
		days of opioid (narcotic pain		Systematic Changes:	
		s not coded as receiving any ns during this review period.		The Staff Development Coordin Director of Nursing or Nursing S educated Licensed Nurses whe	Supervisor
		ation Administration Record 22, through January 11,		receiving physician or physician or content or obtain a 14-day stop of the sto	
		as needed for 37 doses in		psychotropic medications presc an as needed basis or to ensure	
	11/16/22, 36 doses w			rationale and duration for contin documented. After 2/20/23 Lice	ensed
	December, and 13 dc January.	ses were administered in		Nurses will not be permitted to without receiving the aforement education from the Director of N	ioned
	on 01/11/23 at 4:45 P	Director of Nursing (DON) M revealed the as needed		Staff Development Coordinator Director of Nursing, or Nurse St	, Assistant
		vas an active order up until the order should have had a		On 1/23/23 the Regional Vice P	President of

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DEPARTMENT OF HEALTH A				PRINTED: 02/22/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	B. WING _		C 01/20/2023
NAME OF PROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, Z	IP CODE
ACCORDIUS HEALTH AT WILMI	NGTON		820 WELLINGTON AVENUE	
ACCORDIDS HEALTH AT WILMI		WILMINGTON, NC 28401		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE. CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
order in the system order with the physic An interview was co 01/11/23 and 12:20 psychotropics should should have clarifie She stated she ove orders in for Reside An interview with N 01/12/23 at 1:10 PM realized the PRN C a stop date until yes the pharmacy recor changed it to be scl A phone interview w Consulting Pharma The Consulting Pharma The Consulting Pharma were orders for as r should always inclu no psychotropic me days unless there w Consulting Pharma keep the residents	A stated the nurse that put the should have clarified the ician and obtained a stop date. Onducted with Nurse #8 on PM. She stated the PRN Id have a stop date and she d the order with the provider. rlooked it when putting the ent #24. urse Practitioner #2 on A revealed she had not lonazepam order did not have sterday when she was given nmendations, and she	F	 Clinical Services educat Management Leaders (I Nursing, Assistant Direct and Unit Manager) on re- providing to the attending physician extender the precommendations. The Nursing will be responsi pharmacy recommenda communicated to the phy physician extender and recommendations / ordet implemented by the Nur Leaders. Newly hired licensed nur nurses will receive educt working or as part of the orientation, by the Staff Coordinator or Nursing 3 obtaining a 14-day stop psychotropic medicatior an as needed basis or et and duration for continue documented. Monitoring: The Director of Nursing will conduct audits of ter needed psychotropic me for 14-day stop dates or duration for continued u Monitoring will be comp three months and as ne thereafter. The Consulta Recommendation to be completion by the Direct each month for three motion 	ted the Nurse Director of stor of Nursing, eviewing and og physician or obarmacy Director of ble for ensuring tions are hysician or follow-up ers are se Management rses and agency eation, prior to e new hire Development Supervisor on date for all ns prescribed on ensure a rationale ed use is or Unit Manager n residents with as edication orders rationale and se is documented. leted weekly for cessary ant Pharmacist audited for tor of Nursing

Event ID: 7KD011

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/22/2023 M APPROVED O. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345236	B. WING			C / 20/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	JS HEALTH AT WILMING	TON	8	320 WELLINGTON AVENUE		
ACCORDI			N N	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 758 F 759		ror Rts 5 Prcnt or More	F 758 F 759	Administrator or Director of Nursing report the audit findings to the Qua Assurance Performance Improvem Committee monthly for a minimum three months. The Quality Assuran Performance Improvement Commi make recommendations to the plar necessary to assure compliance is sustained ongoing.	lity ent of ce ttee will	2/20/23
SS=D	percent or greater; This REQUIREMENT by: Based on observation interviews the facility medication error rate evidenced by 3 medic opportunities resulting of 10.71% for 2 of 4 re Resident #24) observ administration. Findings included: 1) Resident #24 was a	ion error rates are not 5 is not met as evidenced ns, record review, and staff failed to maintain a of less than 5% as cation errors out of 27 g in a medication error rate esidents (Resident #14 and ed for medication		F759 POC Address how corrective action will accomplished for those residents for have been affected by the deficient practice: Resident #22 and Resident #14 are currently receiving their medication physician's order. Address how the facility will identify residents having the potential to be affected by the same deficient pract	ound to s s per y other	
	The Minimum Data Se assessment dated 11. #24 was cognitively in	/07/22 revealed Resident		Residents who have physician's or medication have been identified as the potential to be affected.		

Event ID: 7KD011

Facility ID: 923408

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE SUF	938-039
	CORRECTION	IDENTIFICATION NUMBER:		G	COMPLET	
		0.45000		С		
		345236	B. WING		01/20/2	2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
ACCORDIUS HEALTH AT WILMINGTON				820 WELLINGTON AVENUE 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE CO	(X5) OMPLETIO DATE
F 759	Continued From page	- 5 <i>1</i>	F 75	50		
1 700	Physician orders writ order for Carvedilol 1 tablet by mouth twice pressure and an order mg give one tablet by pressure. No blood p were written as part of indicate blood pressur- held. The Medication Admi January 2023 reveale Carvedilol orders wer record blood pressure prescribed time to be blocks for the blood p were marked with an recorded next to the a Amlodipine and Carv Medication Aide (MA key coding for chartin	ten on 11/06/22 revealed an 2.5 milligrams (mg) give one daily for high blood er for Amlodipine Besylate 5 mouth daily for high blood ressure or pulse parameters of the physicians' orders to are medications should be nistration Record (MAR) for ed the Amlodipine and re noted to have a block to e and pulse along with the given. On 01/11/23 the pressure and pulse readings	F	Address what measures place or systemic change ensure that the deficient recur: The Staff Development C Director of Nursing, Unit Nurse Supervisor in Chan education to each Licens Certified Medication Aid of medication administratior physician's orders for me administration and not ru medication administration Licensed Nurse or Certifi Aid who did not receive th 2/20/23 will not be permit will receive the education of their next scheduled si Nurse or Certified Medica permitted to work after 2/ receiving the education.	es made to practice will not Coordinator, Manager, or rge provided sed Nurse and on the rights of n, following edication shing through n pass. Any ed Medication he education by tted to work and n prior to the start hift. No Licensed ation Aid will be	
	MA #4 on 01/11/23 w was conducted. MA medications in the me 40 mg one tablet, Lar Omeprazole 20 mg o one tablet and Clona: MA #1 administered t #24 at 9:21 AM and s medication pass for F During a reconciliation that were ordered to	n review of all medications be given to Resident #24 at ation pass on 01/11/23 at		The Staff Development C Director of Nursing, Unit Nurse Supervisor in Char education to each Licens Certified Medication Aid o if they have concerns abo a medication per physicia include notification of a lic physician for further direc Licensed Nurse or Medic not receive the education not be permitted to work the education prior to the next scheduled shift. No or Certified Medication Ai	Manager, or rge provided sed Nurse and on actions to take out administering an's order to censed nurse or ction. Any sation Aid who did h by 2/20/23 will and will receive start of their Licensed Nurse	

Facility ID: 923408

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CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO.0584-0351 AVERALTH OF CIRCINCIPSIES V23 MULTIPLE CONSTRUCTION ID STATUSTON FOR THE UNCEY AND OF PROVIDER OR SUPPLIER 345256 D. WNG C ACCORDUS HEALTH AT WILLINGTON SUBMAY STRENENT OF DEPOSINGES D. WNG C 01120/2023 ACCORDUS HEALTH AT WILLINGTON SUBMAY STRENENT OF DEPOSINGES D. WNG EXECUTED NOT SUBJECT ON USED BENCINCIES D. WNG F 759 Continued From page 55 F 759 PROVIDER OR SUBPLIER D. WNG D.	DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	1 APPROVED
AND FLAN OF CORRECTION DENTIFICATION NUMBER: A. BULDING COMPUT 346236 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE C ACCORDUUS HEALTH AT WILLINGTON STREET ADDRESS, CITY, STATE, ZIP CODE C C ACCORDUUS HEALTH AT WILLINGTON SUMMAY SINTMANT OF DEPOCIENTING INFORMATION SUMMAY SINTMANT OF DEPOCIENTING INFORMATION PROVIDER VIA SUBJECT ON THE APPROPRIATE COMPACTION Marger, TAG SUMMAY SINTMANT OF DEPOCIENTING INFORMATION TAG PROVIDER VIA SUBJECT ON THE APPROPRIATE Conference Particle SUMMAY SINTMANT OF DEPOCIENTING INFORMATION TAG PROVIDER VIA SUBJECT ON THE APPROPRIATE Conference F 759 Continued From page 55 receiving the education. F 759 receiving the education. Configuration F 759 Continued From page 55 receiving the education Administration F 759 receiving the education. Configuration. F 759 Continued From page 55 receiving the education. F 759 receiving the education Administration Pass Competency with the Director of Nursing. Unit Manager. Staff Development Coordinator or Nursing Supervisor Coordinator or Nursing Supervisor Coordinator or Nursing Supervisor Coordinator or Nursing. Nut statad she believed the accision to hord the blood pressure medications. Nursing Assistant Director of Nursing.								
C C MARE OF PROVIDER OR SUFFILER ACCORDUS HEALTH AT WILLINGTON C C DATE OF PROVIDER OF SUFFILER C DIFICUATION CONTINUER STREET ADRESS, CITY, STATE, ZIP CODE ACCORDUS HEALTH AT WILLINGTON DIFICUATION VENUE C DIFICUATION STREET ADRESS, CITY, STATE, ZIP CODE CONTINUES CONTRACTION VENUE CONTRACTION VENUE DIFICUATION VENUES ENTRECTION ADRESS DIFICUATION VENUES ENTRECTION ADRESS TOTAL PORTOCINCE CONTRACTION VENUE TOTAL CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES TOTAL CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES CONTRACTION VENUES CONTRACTION								
345236 B-WNO 01120/2023 NMME OF PROVIDER OR SUPPLENT STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON XENUE WILLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON, NC 23401 STREET ADDRESS. CITY, STATE, ZP CODE 320 VELLINGTON, NC 23401 STREET ADDRESS, CITY, STATE, ZP CODE 320 VELLINGTON, NC 23401 STREET ADDRESS, CITY, STATE, ZP CODE 320 VELLINGTON, NC 23401 STREET ADDRESS, S				A. BUILDI	NG _			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE JP CODE ACCORDUS HEALTH AT WILMINGTON STREET ADDRESS, CITY, STATE JP CODE 30 WELLINGTON AVENUE (Page 1)X SUMMARY STATEMENT OF DEFICIENCES IP PROVIDERS IF, AND CORRECTIVE ACTORS SHOLL DE ELECTRONY COMBETION (Page 1)X SUMMARY STATEMENT OF DEFICIENCES IP PROVIDERS IF, AND CORRECTIVE ACTORS SHOLL DE ELECTRONY COMBETION (Page 1)X SUMMARY STATEMENT OF DEFICIENCES IP PROVIDERS IF, AND CORRECTIVE ACTORS SHOLL DE ELECTRONY COMBETION COMETION COMBETION COMBETION								-
B28 VELLINGTON AVENUE VILIMINGTON, NC 23401 COORDING SUMMARY SIMENATION OF DEFIDIENCES INCOMMENTION, NC 23401 Construction (EACH CORRECTIVE CONSTITUTION OF DEFIDIENCES) (EACH CORRECTIVE CONSTITUTION (EACH CORRECTIVE CONSTITUTION) (EACH CORRECTIVE CONSTITUTION) (EA			345236				01/:	20/2023
ACCORDUS HEALTH VILLINISTON WILLINGTON, NC 28401 (M) ID PRETIX TAS ID RECOMPRETIVENT OF DEFICIENCIES (EACH DEPICIENCY ONLISE IS PRECIDE OF FILL RECOULTIONT ONLISE IDENTIFYING INFORMATION) ID PRETIX TAS PROVIDERST PLANOF CORRECTION (EACH OPECIDENTIFYING INFORMATION) 000 F 759 Continued From page 55 ordered. F 759 F 759 receiving the education. Each Licensed Nurse and Medication Aid Will Have a Medication Administration pressure was low. MA #4 was unable to find the recordings of what the blood pressure medications. F 759 MA #4 stated she believed it was 102/82 and she felt that was too low to administer the resident her blood pressure medications. Each Licensed Nurse and Medication Aid Will Have a Medication Aid who does not pass. F 759 MA #4 stated the blood pressure medications. M4 #4 stated here tholod to hold the medication and she should have notified the nurse before making the decision to hold the blood pressure medications. MA #4 stated here were no parameters ordered to hold the medication and she should have notified the nurse before making the decision to withhe DioON yon 011/12/23 at 4.45 PM. The DON reported she would have expected MA #4 to noffly the nurse in charge what the blood pressure and pubse and the MA should not have made the decision to withhold the blood pressure medications. After 220/23 no Licensed Nurse and Medication Administration Pass Competency with the Director of Nursing, Unit Manager, Staff Development Coordinator of Nursing, Unit Manager, Staff Development Coordinator of Nursing, Unit Manager, Staff Development Coordinator of Nursing, Unit Manage	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(Muintation, No. 2 additional pressure was built to the biocop pressure medications. MA #4 was unable to find the recordings of what the biod pressure was low. MA #4 was unable to find the recordings of what the biod pressure was built stated she believed it was 102/82 and she fet that was too low to administer the resident her biod pressure medications. MA #4 was unable to find the recordings of what the biod pressure was built stated she believed it was 102/82 and she fet that was too low to administer the resident her biod pressure medications. MA #4 stated she had not notified the charge nurse at this time, and she was waiting to finish her medications. F 759 F 759<	ACCORDI	US HEALTH AT WILMING	STON		8	20 WELLINGTON AVENUE		
PRETRY TAG IEACH CORRECTIVATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONSTRUCTIVATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 759 Continued From page 55 ordered. F 759 F 759 receiving the education. Each Licensed Nurse and Medication Aid will have a Medication Administration pressure medications because her blood pressure medications because her blood pressure medications. F 759 receiving the education. Base Competency with the blood pressure was low. MA 44 was unable to find the recordings of what the blood pressure was low. that was too low to administer the resident her blood pressure medication. An interview was conducted with the Director of Nursing (DON) on 1/12/23 at 445 PM. The DON reported she would have expected MA #4 to notify the nurse hefore making the decision to hold the blood pressure medications. Not without direct supervision. The Licensed Nurse on Medication Administration Pass Competency will have immediate one to nor re-ducation and will not be permitted to work without direct supervision. The Licensed Nurse or Medication Administration Pass Competency and must pass the completency and must pass the competency and must pass the competency and must pass the competency and must pass the competency with the Director of Nursing Supervisor. 2) Resident #14 was admitted to the facility on 09/03/13 with diagnosis to include high blood pressure and coronary artery disease. Afre 2/20/23 no Licensed Nurse and Medication Administration Pass Competency with the Director of Nursing Supervisor. A review of the physician orders revealed an order written on 05/13/22 for Metoprold Suciante Extended Release 25 mg give one	Accordi				v	VILMINGTON, NC 28401		
Trig REGULATORY OR LSC IDENTIFYING INFORMATION) Trig CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY DWE F 759 Continued From page 55 ordered. F 759 F 759 receiving the education. Each Licensed Nurse and Medication Aid will have a Medication Aid will have a Medication Aid ministration pressure madications because her blood pressure was but stated she believed it was 102/82 and she felt that was too low to administer the resident her blood pressure were no parameters ordered to hold the charge nurse at this time, and she was waiting to finish her medication pass. Each Licensed Nurse and Medication Aid will have immediate one to one re-education hard who does not pass the Medication Aid will be given another Medication Aid will be given a	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
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notify the nurse in charge what the blood pressure and pulse reading was and the MA should not have made the decision to withhold the blood pressure medications.Pass Competency and must pass the competency in order to work independently.2) Resident # 14 was admitted to the facility on 09/03/13 with diagnosis to include high blood pressure and coronary artery disease.After 2/20/23 no Licensed Nurse and Medication Aid will be permitted to administer medications without having a Medication Aid will be permitted to administer medication of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.An observation of medication administration withAn observation of medication administration withManager, or Nurse Supervisor in Charge								
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should not have made the decision to withhold the blood pressure medications.independently.2) Resident # 14 was admitted to the facility on 09/03/13 with diagnosis to include high blood pressure and coronary artery disease.After 2/20/23 no Licensed Nurse and Medication Aid will be permitted to administer medications without having a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge								
the blood pressure medications.After 2/20/23 no Licensed Nurse and Medication Aid will be permitted to administer medications without having a Medication Aid will be permitted to administer medications without having a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge			-					
2) Resident # 14 was admitted to the facility on 09/03/13 with diagnosis to include high blood pressure and coronary artery disease.Medication Aid will be permitted to administer medications without having a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge								
09/03/13 with diagnosis to include high blood pressure and coronary artery disease.administer medications without having a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge		-				After 2/20/23 no Licensed Nurse and		
pressure and coronary artery disease.Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge								
The annual MDS assessment dated 10/28/22 revealed Resident #14 was cognitively intact.Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge						administer medications without having	а	
The annual MDS assessment dated 10/28/22 revealed Resident #14 was cognitively intact.Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge		pressure and coronar	y artery disease.					
revealed Resident #14 was cognitively intact.Manager, Staff Development Coordinator or Nursing Supervisor.A review of the physician orders revealed an order written on 05/13/22 for MetoprololAny newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge							ng,	
A review of the physician orders revealed an order written on 05/13/22 for Metoprololor Nursing Supervisor.Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge						-		
A review of the physician orders revealed an order written on 05/13/22 for MetoprololAny newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge		revealed Resident #1	4 was cognitively intact.				tor	
order written on 05/13/22 for MetoprololAny newly hired License Nurse and newlySuccinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge						or Nursing Supervisor.		
Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge						Any nowly bired License Nurse and re-	why	
tablet by mouth daily for high blood pressure.the education from the Staff Development Coordinator, Director of Nursing, UnitAn observation of medication administration withManager, or Nurse Supervisor in Charge							-	
An observation of medication administration withCoordinator, Director of Nursing, UnitManager, or Nurse Supervisor in Charge								
An observation of medication administration with Manager, or Nurse Supervisor in Charge		ablet by mouth dally	ior nigh blood pressule.				on	
		An observation of me	dication administration with			-	ne	
						on following physician's orders for	, ·	

Facility ID: 923408

If continuation sheet Page 56 of 78

-		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С	
		345236	B. WING		01/20/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
	US HEALTH AT WILMIN	GTON	8	20 WELLINGTON AVENUE	
ACCORD			v	VILMINGTON, NC 28401	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIC
F 759	Continued From pag	e 56	F 759		
		AM was conducted. MA #4		medication administration and not	rushina
		v all the medication cards		through medication administration	u
		cart of the meds that were to		and actions to take if they have co	
	be dispensed which i	included Lisinopril 2.5 mg,		about administering a medication	per
	Protonix 40 mg, Pota			physician's order to include notification	
r r f S t		dnisone 5 mg, Sertraline 150		a licensed nurse or physician for fu	urther
		mg, Metoprolol Succinate 25		direction during their classroom	
	0, 1	ng. MA #1 was observed		orientation, prior to provision of ca	re.
		/hile putting one tablet of a l one tablet of 100 mg		Any agency License Nurse or age	nov
	-	ication cup followed by 1		Certified Medication Aid will receiv	-
		other medications except the		education from the Staff Developm	
		and putting the cards back		Coordinator, Director of Nursing, L	
		as noted to not remove any		Manager, or Nurse Supervisor in C	
	medication from the	Metoprolol Succinate card,		on following physician's orders for	
		e card back in the medication		medication administration and not	-
		ner medication cart, locked		through medication administration	
		o walk away from the cart to		and actions to take if they have co	
		MA #1 was asked if she had		about administering a medication	
		g all of Resident #14's eplied, "Yes." MA #4 was		physician's order to include notificate a licensed nurse or physician for fu	
		umber of medications she		direction, prior to provision of care	
		cup. The MA counted her			
		At this time, the medications			
		s removed from the cards		Indicate how the facility plans to m	onitor
		/A #4. MA #4 stated she		its performance to make sure that	
		oprolol Succinate in the		solutions are sustained:	
		nad put the card away. MA			
		oprolol and added it to the		Five times weekly for twelve week	
	-	administered to Resident he needed to slow down		Director of Nursing, Assistant Dire	
		nsing her medications.		Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly	4
		nong nor mediodiona.		observe ten residents' medication	y
	An interview was cor	nducted with the Director of		administration pass to validate	
		1/12/23 at 4:45 PM. The		medications were administered pe	r order
		ould expect MA #4 to take		or that the physician was notified f	
		nedication pass to make sure		further orders. During the auditing,	
	she was not omitting	any medications that		noted that that the process was no	ot
	needed to be adminis			followed, the Licensed Nurse or	

Facility ID: 923408

		MEDICAID SERVICES			OMB NO. 0938-0			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED				
		345236	B. WING	C 01/20/2023				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE WILMINGTON, NC 28401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET			
F 759 F 760 SS=E	Residents are Free o CFR(s): 483.45(f)(2) The facility must ensi §483.45(f)(2) Reside medication errors. This REQUIREMENT	of Significant Med Errors	F 75	Medication Aid will be removed from patient care and a one-to-one educe in-service will be provided by the D of Nursing or Staff Development Coordinator. The Licensed Nurse of Medication Aid will not be permitted provide patient care until they can correctly state the facility's process ordering medication. Additionally, the daily for four weeks, a house wide observational audit of the Electroni Medical Record Dashboard will be performed by the Director of Nursin Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in C to assure each resident's medication administered per physician order. The audits will be presented by the Direc Nursing to the facility's Quality Assument Committee for review monthly for the months. The facility's Quality Assument Committee will make recommenda as needed to assure compliance is sustained ongoing.	cational irector			
	interviews, Pharmacy	ons, record review, staff y Supervisor, Pharmacy ractitioner and Physician the facility failed to		F760 POC Address how corrective action will accomplished for those residents for				

Event ID: 7KD011

Facility ID: 923408

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	TED: 02/22/202 DRM APPROVEI NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		345236	B. WING _			C 01/20/2023	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT WILMING	GTON			20 WELLINGTON AVENUE ILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	Continued From page	- 58	E T	760			
		of Valproic Acid Solution for rved for significant			have been affected by the deficient practice:		
	Findings included:				Resident #22 is currently receiving the medications per physician's order.	neir	
		mitted to the facility on included schizoaffective disorder.			Address how the facility will identify or residents having the potential to be affected by the same deficient praction		
	order was written on Solution 250 mg per	cian orders revealed an 06/11/20 for Valproic Acid 5 milliliters (ml) give 625 mg laily for schizoaffective			Residents who have physician's orde medication have been identified as h the potential to be affected.		
	disorder.				Residents who receive medication hat been identified as having the potentia		
	#22 was moderately	2/16/22 revealed Resident			be affected. On 2/13/23 the Director of Nursing, Assistant Director of Nursing, and Ur Manager conducted a house-wide	nit	
	back period.	edication during this look			baseline audit to compare the Medica Administration Record to medications hand for each resident to assure each	s on h	
	review for Resident #				resident had medication readily avail per physician order. Any medication was not readily available was re-orde	that ered	
	01/06/23, 01/08/23, 0 Valproic Acid Solution #9 recorded for the 9	/03/23, 01/04/23, 01/05/23, 11/09/23, and 01/10/23 the n order for 625 mg had the :00 AM dose on 01/02/23, #9 recorded for both doses			and the attending physician or physic extender was notified for further orden needed, a medication variance repor completed.	rs. If	
	(9:00 AM and 9:00 PI 01/06/23, 01/08/23, 0	M on 01/04/23, 01/05/23, 11/09/23, and 01/10/23. oding on the MAR revealed			Address what measures will be put in place or systemic changes made to ensure that the deficient practice will recur:		
	A review of the electron administration notes to 01/02/23 revealed:				The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided		

Facility ID: 923408

If continuation sheet Page 59 of 78

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 02/22/202 RM APPROVE O. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345236	B. WING _	B. WING			C I/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ACCORDIUS HEALTH AT WILMINGTON			82	20 WELLINGTON AVENUE		
ACCORDI				W	/ILMINGTON, 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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 760	Continued From page	e 59	F 7	760			
					education to each Licensed Nurse a	nd	
	Valproic Acid So	lution note indicated "waiting			Certified Medication Aid on following		
		/03/23 and 01/04/23 the			physician's orders for medication		
		Iproic Acid Solution was "on			administration. Any Licensed Nurse	or	
	order,"				Certified Medication Aid who did not		
	" On 01/08/23 the			receive the education by 2/20/23 will	not		
	Acid Solution was "re	•			be permitted to work and will receive		
	" There were no m	nedication notes for 01/05/23,			education prior to the start of their ne	ext	
	01/06/23, 01/09/23, c	or 01/10/23 indicating why			scheduled shift. No Licensed Nurse	or	
	the Valproic Acid Solu	ution was not given.			Certified Medication Aid will be perm	itted	
					to work after 2/20/23 without receiving	ng the	
		e medication cart on 01/13/23			education.		
	at 12:40 PM revealed						
		n for Resident #22 with a			The Staff Development Coordinator,		
		ne order date was 01/06/23			Director of Nursing, Unit Manager, o		
	and an opened date	of 01/11/23.			Nurse Supervisor in Charge provide education to each Licensed Nurse o	n	
		ducted with Medication Aide			timely medication reordering to ensu		
		at 8:40 AM. She stated on			medication is available. Any License		
		ented the #9 which meant			Nurse who did not receive the educa		
		the Valproic Acid Solution			by 2/20/23 will not be permitted to w		
		ause it was not available and			and will receive the education prior to		
		he point click care (PCC)			start of their next scheduled shift. No		
		system that was connected eordering and receiving			Licensed Nurse will be permitted to v after 2/20/23 without receiving the	NOIK	
		w it had been reordered so			education.		
		g on pharmacy" in the					
		tated she believed she told			The Staff Development Coordinator,		
		available on 01/02/23.			Director of Nursing, Unit Manager, o		
					Nurse Supervisor in Charge provide		
	An interview with Nur	rse #10 on 01/11/23 at 3:30			education to each Licensed Nurse a		
		Ild not recall if she was made			Certified Medication Aid on actions to		
		1/02/23 that the Valproic			if a medication is not readily availabl		
		t available for Resident #22.			Any Licensed Nurse or Medication A		
					who did not receive the education by		
	An interview was con	ducted with the Unit			2/20/23 will not be permitted to work	and	
	Manager (UM) on 01	/11/23 at 3:10 PM. She			will receive the education prior to the	e start	
		h Aide should have let the			of their next scheduled shift. No Lice		
	nurse or her know the	e Valproic Acid Solution was			Nurse or Certified Medication Aid wil	l be	

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					OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345236	B. WING		01/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE WILMINGTON, NC 28401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE
F 760	Continued From page	e 60	F 76	30	
	not available on her of gotten the medication	cart and we could have n ordered for the resident. on Aides and Nurses have		permitted to work after 2/2 receiving the education.	20/23 without
	Manager or Pharmac prescribed medicatio acceptable to keep re up on where the med A phone interview wa Pharmacy Superviso The Pharmacy Superviso The Pharmacy Superviso Acid Solution for Res 01/06/23 and receive facility on 01/07/23 at Supervisor stated mis Acid could cause the behavioral issue and resident.	as conducted with the r on 01/13/23 at 10:20 AM. rvisor stated the Valproic sident #22 was ordered on ed and signed for at the t 8:17 AM. The Pharmacy ssing doses of the Valproic resident to have increased could be distressful on the		Each Licensed Nurse and will have a Medication Ad Pass Competency with th Nursing, Assistant Director Unit Manager, Staff Deve Coordinator or Nursing St completed on or before 2/ Licensed Nurse and Medi does not pass the Medica Administration Pass Com have immediate one to or and will not be permitted direct supervision by the I Nursing, Assistant Director Unit Manager, Staff Deve Coordinator or Nursing St Licensed Nurse or Medication Base Competency and medication	ministration e Director of or of Nursing, lopment upervisor /20/23. Any ication Aid who ation petency will ne re-education to work without Director of or of Nursing, lopment upervisor. The ation Aid will be Administration
	worked on the medic to the Charge Nurse stated if she did not s on the cart, she woul document on the MA the nurses notes why given and notify the o given. She stated on 01/10/23 she recorde Acid Solution for Res because she did not drawer. She stated s	M. MA #5 reported when she ation cart, she would report assigned to that hall. She see an ordered medication d reorder it on PCC, R the #9 and put a note in / the medication was not charge nurse that it was not o 01/03/23, 01/09/23, and ed the #9 for the Valproic sident #22 on the MAR see the medication in the she could not remember if if it had been reordered.		 Pass Competency and m competency in order to w independently. After 2/20/23 no Licensect Medication Aid will be per administer medications w Medication Administration Competency with the Direc Assistant Director of Nurs Manager, Staff Developm or Nursing Supervisor. Any newly hired License I 	ork I Nurse and mitted to ithout having a p Pass ector of Nursing, sing, Unit tent Coordinator
	bottle of Valproic Acid cart and confirmed it	MA #5 identified the open d Solution in the medication was received on 01/07/23 //23. She stated she did not		hired Certified Medication the education from the St Coordinator, Director of N Manager, or Nurse Super	aff Development lursing, Unit

Facility ID: 923408

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE	CONSTRUCTION	OMB NC	
	CORRECTION	IDENTIFICATION NUMBER:				1 1 1	LETED
						С	
		345236	B. WING			01/	20/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILMING	STON	820 WELLINGTON AVENUE				
ACCORDI		310N		W	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 760	Continued From page	e 61	F 76	60			
		alproic Acid Solution being			on following physician's orders for		
	-	t on 01/03/23, 01/09/23 or			medication administration on timely		
	01/10/23.				medication reordering to ensure		
					medication is available, and on actions		
		ducted with Nurse #11 on			take if a medication is not readily availa		
		 Nurse #11 confirmed she 			during their classroom orientation, prio	r to	
	worked on 01/06/23 a				provision of care.		
		n the MAR for the Valproic					
		ident #22. She stated she			Any agency License Nurse or agency		
		rses note in the electronic			Certified Medication Aid will receive the	9	
		ndicate why it was not given tated on 01/06/23 and			education from the Staff Development		
	-	d the medication storage			Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Char	90	
		one in there. She stated			on following physician's orders for	ye,	
		⁷ MA #5 notified her on			medication administration on timely		
		proic Acid Solution was not			medication reordering to ensure		
		During this interview,			medication is available, and on actions	s to	
	Nurse #11 reviewed t	he medication cart and			take if a medication is not readily availa	able	
	confirmed the bottle of	of Valproic Acid Solution for			prior to provision of care.		
	Resident #22 was in t	the medication draw and					
		01/06/23 and delivered on			Indicate how the facility plans to monite	or	
		ned date on 01/11/23. She			its performance to make sure that		
		explain why it was not given			solutions are sustained:		
		9/23 if it had been delivered			Five times weakly far to be used to the		
		e reviewed the MAR and saw on had been given for both			Five times weekly for twelve weeks the Director of Nursing, Assistant Director		
		nd stated "it must have been			Nursing, Unit Manager, or Nurse	U	
	in the cart if it was giv				Supervisor in Charge will randomly		
		he could not recall being			observe ten residents' medication		
		ation Aides that the Valproic			administration pass to validate		
	-	t given to Resident #22 on			competency to include medications we	ere	
		when she was the Charge			administered per order or that the		
		Nurse #11 stated she			physician was notified for further order	s.	
	believed she noted in	-			During the auditing, if it is noted that th	at	
		which was kept at the			the process was not followed, the		
	-	ne medications were not			Licensed Nurse or Medication Aid will I	be	
	available, and Reside	ent #22 did not receive them.			removed from patient care and a		
					one-to-one educational in-service will b	be	
	An interview was con	ducted with the Nurse			provided by the Director of Nursing or		

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		ND HUMAN SERVICES MEDICAID SERVICES				RINTED: 02/22/2023 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		345236	B. WING _			C 01/20/2023
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
				820 WELLINGTON AVENUE		
ACCORD	US HEALTH AT WILMIN	GION		WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 760	Practitioner (NP) on (NP stated Resident # Solution to treat schiz stated she was not ar receiving the medicat #22 to have breakthropotential for negative interview, the physici reviewed for January documentation to ind received the Valproic assessed Resident # had her baseline and not receiving the medicat spoke with the nursin behavioral issues as medication. She stat consider reducing the A phone interview with (PA) on 01/13/23 at 3 the first time she was not receiving her Valp she would have want she was missing any She stated the reside schizoaffective disord could have caused her She stated if nurses a documenting medicat would expect them to medication to make s notify her for addition An interview with the	201/13/22 at 1:10 PM. The #22 was getting Valproic Acid coaffective disorder. She ware the resident was not tion as ordered and that not tion could cause Resident ough symptoms with the side effects. During this an communication book was 2023 and there was no icate Resident #22 had not Acid Solution. The NP 22 and reported she was had no adverse effects from dications as ordered. She the medical records and ng staff, and she has had no a result of not receiving the ted knowing this she would a dose. th the Physician Assistant 5:50 PM revealed this was a hearing about Resident #22 proic Acid. The PA stated ted to have been notified if doses of the Valproic Acid. ent has a history of der and missing those doses er to become unbalanced. and medication aides were tion "not available," she b be following up on the sure it was available and to al orders if needed. Regional Clinical Vice 3 at 4:55 PM revealed there	F7	760 Staff Development Coo Licensed Nurse or Med be permitted to provide they can correctly state process for ordering me Additionally, twice daily house wide observation Electronic Medical Rec be performed by the Di Assistant Director of Nu Manager, or Nurse Sup to assure each resident administered per physic audits will be presented Nursing to the facility's and Performance Impro Committee for review n months. The facility's C and Performance Impro Committee will make re as needed to assure co sustained ongoing.	lication Aid will not patient care until the facility's edication. of four weeks, a nal audit of the ord Dashboard wil rector of Nursing, ursing, Unit pervisor in Charge t's medication is cian order. The d by the Director of Quality Assurance povement nonthly for three Quality Assurance povement ecommendations	1

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 02/22/202 APPROVE . 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/20/2023	
		345236	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	OPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 760	Continued From page	e 63	F 76	0		
		s as well as notifying the				
	-	a medication was not d she would expect nursing				
		esidents were receiving their				
	prescribed medicatio					
		re notifying the Charge dications were not available.				
	Nulses when the me					
	-	as conducted with the				
	-	t on 01/18/23 at 11:27 AM.				
		ation was not available, she sing staff to research as to				
	when it was reordere	d and when it would arrive				
		sician for additional orders				
		arrived. She stated just and not following through				
		ould expect the nursing staff				
		ed, "there needs to be follow				
		Consultant stated she did 2 was as risk for any serious				
		of not receiving the Valproic				
	Acid because it was					
F 761		der and not to treat seizures.	F 76	1		2/20/23
F 761 SS=D	Label/Store Drugs ar CFR(s): 483.45(g)(h)		F 70	1		2/20/23
		of Drugs and Biologicals				
		s used in the facility must be				
	professional principle	e with currently accepted				
	appropriate accessor					
	instructions, and the applicable.	expiration date when				
	§483.45(h) Storage o	of Drugs and Biologicals				
	§483.45(h)(1) In acco	ordance with State and				

Facility ID: 923408

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	-	D HUMAN SERVICES MEDICAID SERVICES			APPROVED 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SI COMPLE			
		345236	B. WING		_	0/2023		
NAME OF P	ROVIDER OR SUPPLIER			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)	Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 761	biologicals in locked of temperature controls, personnel to have accontrols personnel to have accontrol of storage of controlled the Comprehensive D Control Act of 1976 and abuse, except when the package drug distribut quantity stored is mini- be readily detected. This REQUIREMENT by: Based on observation facility failed to keep of stored in a locked me medication carts obsec cart) during a medication and on 01/11/23 at 9:20 A (MA) #4 on the 500 h dispensing her medication and bringing them to locking her cart. MA facing a resident's roo observed in the hallw residents in their whe cart. An interview was con 01/11/23 at 9:22 AM. rushing to finish her medication for the second of the second second second second of the second second second second second second second second bringing them to locking her cart. MA	compartments under proper and permit only authorized cess to the keys. affixed compartments for drugs listed in Schedule II of brug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced hs and staff interviews the unattended medications dication cart for 1 of 3 erved (500 hall medication tion pass. administration observation M with Medication Aide all, MA #4 was observed ations into a medication cup the resident without first #4 had the medication cart om. Several staff were ay at this time including two elchairs propelling by the ducted with MA #4 on The MA stated she was hedication pass and she re the medication cart was	F 76	F 761 POC Address how corrective action will be accomplished for those residents foun have been affected by the deficient practice: When not attended, the 500 Hall medication cart is currently being locked with medications secured. Address how the facility will identify oth residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected. Address what measures will be put inter place or systemic changes made to ensure that the deficient practice will n recur: The Staff Development Coordinator	ed ner :: :he			

Facility ID: 923408

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/22/2023 MAPPROVED D: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345236	B. WING				C 20/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILMING	STON		82	20 WELLINGTON AVENUE		
ACCORDI	US HEALTH AT WILMING			N	VILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE JLATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION		BE	(X5) COMPLETION DATE		
F 761	on 01/11/23 at 9:30 A hall was conducted. #4 had the medication room. She was unab nasal spray in her me the cart, but left the to exposed several oper over-the-counter med pens, nasal spray bol walked away stating s medication storage ro #4 was away from he minutes. Several sta hallway at this time in their wheelchairs prop An interview was con 01/11/23 at 9:34 AM. rushing, and she did to drawer opened when An interview was con Nursing on 01/22/23 a stated she expected to	administration observation M with MA #4 on the 500 During the observation, MA in cart facing the resident's le to locate a resident's edication cart. She locked op drawer opened and hed bottles of lications, insulin injection itles and eye drops and she would check the bom for the nasal spray. MA r unsecured cart for 4 ff were observed in the iccluding three residents in belling by the cart. ducted with MA #4 on MA #4 stated she was not realize she left the top she locked the cart. ducted with the Director of at 4:40 PM. The DON the nursing staff to secure a anytime they were leaving	F	761	educated the Licensed Nurses and Certified Medication Aides to secure to medication cart when not in use and to not leave medications unattended. Aft 2/20/23 no Licensed Nurses of Certific Medication Aides will be permitted to without receiving the aforementioned education from the Director of Nursing Staff Development Coordinator, Assis Director of Nursing, or Nurse Supervise Newly hired Licensed Nurses and Certified Medication Aides will be educated during their classroom orientation period to secure the medication cart when not in use and to not leave medications unattended. Indicate how the facility plans to moni- its performance to make sure that solutions are sustained: Five times weekly for twelve weeks the Director of Nursing, Assistant Director Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly observe each medication cart to valid that medications are stored in a locke medication cart when unattended. Du the auditing, if it is noted that that the process was not followed, the License Nurse or Medication Aid will be remov from patient care and a one-to-one educational in-service will be provided the Director of Nursing or Staff Development Coordinator. The License Nurse or Medication Aid will not be	o eer eed work g, tant sor. o tor e tor e d ring ed ed i by sed	
					permitted to provide patient care until can correctly state the facility's proces for ordering medication. The audits wi	s	

Event ID: 7KD011

Facility ID: 923408

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							<u> </u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345236	B. WING				C / 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT WILMIN	IGTON					
				vv	ILMINGTON, NC 28401		1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 761	Continued From pag	ne 66	F 7	61			
		,			presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee make recommendations as needed to assure compliance is sustained ongoin	e for e will	
	QAPI/QAA Improver CFR(s): 483.75(g)(2		F 8	67			2/20/23
	§483.75(g) Quality a	assessment and assurance.					
	assurance committe (ii) Develop and imp action to correct ide This REQUIREMEN	uality assessment and e must: lement appropriate plans of ntified quality deficiencies; T is not met as evidenced					
		ons, record review, and staff y's Quality Assurance &			F867 POC		
	Performance Improv to maintain impleme	vement Program (QAPI) failed inted procedures and monitor e committee put into place ation and complaint			Address how corrective action will be accomplished for those residents foun have been affected by the deficient practice:	d to	
	investigations on 04 was for 4 deficiencie the areas of safe, ho accurate coding of the	/21/22 and 11/08/22. This es that were originally cited in pomelike environment, he minimum data set icant medication errors and			August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President Operations assisted the facility leaders with the review and evaluation of the		
	medication storage a recited on the currer and follow up survey	and were subsequently nt recertification, complaint / of 01/20/23. The continued eys of record shows a pattern			statement of deficiencies (SOD) and ir the development of the plan of correct (POC). Address how the facility will identify oth	ion	
		ity to sustain an effective			residents having the potential to be affected by the same deficient practice		

Event ID: 7KD011

Facility ID: 923408

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/20/2023	
		345236	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		270N	8	320 WELLINGTON AVENUE		
ACCORDI	JS HEALTH AT WILMIN	GION	1	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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 867	Continued From page	e 67	F 867			
	Findings included:		1 007		have the	
	i manys nouded.			Residents residing in the facility potential to be affected.		
	This tag is cross refe	renced to:		The measures the facility will tal	ke to	
	5			ensure the problem will be corre		
	F584: Based on obse	ervations and staff interviews		will not reoccur:		
		a) repair torn floor linoleum		On 2/13/23 the Regional Vice P		
		oms (508, 600, and 603), 1b)		Clinical Services provided education		
		plack greenish substance		training to the Facility Administra		
		ase caulking in 4 of 13		regarding the Quality Assessme Performance Improvement (QA		
		508, 510, and 615), 1c) eilings were free from		process and the need of mainta		
		2 of 4 shower rooms (500		implemented procedures and m		
		liled to repair a broken wall		those interventions put in place	-	
		3 resident rooms (502), 1e)		deficient practice has been alleg		
	failed to replace roug	h, worn, splintered		cited. On 2/13/23, under the dire	ection and	
		and 600 halls, 1f) failed to		supervision of the Regional Vice		
		ode bases in 4 of 13 resident		of Clinical Services, the Adminis		
), and 612). 1g) failed to		provided education and training		
		mage in 3 of 13 resident		Director of Nursing, Assistant D		
		d 615), 1h) failed to replace or tile in 8 of 13 resident		Nursing, Unit Manager, MDS Co (MDSC), Maintenance Director,		
	•), 609, 610, 612, 614, and		Development and Social Service		
		o replace broken window		on the QAPI process and the ne		
		lent rooms (600 and 613).		maintaining implemented proce		
		investigation survey on		monitoring those interventions p		
	11/08/22 the facility fa	ailed to eliminate a strong		after deficient practice has been	alleged	
		he 500/600 hall section of		and cited.		
	0	m care section of the building		Indicate how the facility plans to		
	for 2 of 6 halls observ	ved.		its performance to make sure th solutions are sustained:	at	
		investigation survey on				
	•	ailed to maintain a clean and		An Ad Hoc QAPI meeting was h		
		by mold growing on the wall		2/14/2023, to review the alleged		
		ved for environment (room		practice cited and implement a l		
	200).			Correction. This meeting include		
	F641: Based on reco	rd review and staff		Administrator, DON, ADON, Un Manager, Maintenance Director		
		failed to accurately code the		Coordinator, Social Services Director		
1						

Facility ID: 923408

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			MPLETED
						С
		345236	B. WING		c	1/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ACCORDI	US HEALTH AT WILMIN	GTON		820 WELLINGTON AVENUE WILMINGTON, NC 28401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 867	Continued From pag	e 68	F 86	7		
		(Resident #24) and falls		Services Director, Admission	s Director.	
		of 33 residents reviewed.		and Regional Vice President		
				Services. The QAPI Commit		
		certification and complaint		weekly for (4) weeks starting		
	•	he facility failed to accurately		then monthly until substantia		
		sment for activities of daily sessment was coded as		is obtained, to monitor the im of the plan of correction, incl		
		for eating and toileting use		education component and th		
		dent (Resident #5); and failed		audits, to evaluate the effect		
		n MDS assessment for range		plan of correction and if nece		
	of motion (Resident #	#15) for 2 of 18 residents		provide additional education	and request	
	whose MDS were as	sessed.		additional audits / reports. Th		
				Administrator is responsible		
		ervations, record review, staff		this plan of correction is impl	emented.	
	-	y Supervisor, Pharmacy actitioner and Physician				
	Assistant interviews,					
		of Valproic Acid Solution for				
	1 of 2 residents obse					
	medication errors (Re	-				
	0 1	investigation survey on				
	-	ailed to accurately administer				
		esident #1 was administered				
		ng to Resident #6 to include pressure medication) 50				
		Xanax (an antianxiety				
		sulting in Resident #1 having				
		and a decrease in blood				
	pressure which requi	red her to be sent to the				
	•••	r further evaluation for 1 of 2				
	residents reviewed fo	or medication errors.				
	F761: Based on obse	ervations and staff interviews				
	the facility failed to ke	eep unattended medications				
		edication cart for 1 of 3				
		erved (500 hall medication				
	cart) during a medica	ation pass.				

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/22/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345236	B. WING				C 20/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				820 WELLINGTON AVENU	JE		
ACCORDI	US HEALTH AT WILMING	TON		WILMINGTON, NC 284	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page During the complaint 11/08/22 the facility fa medications stored in 1 of 2 medication cart medication cart). An interview was com- Director of Clinical Se Administrator on 01/1 they believed their QA significant medication storage because they monitoring too soon a sure the nursing staff RDCS and the Admin their QAPI plan was in homelike environmen identify all the probler Infection Prevention & CFR(s): 483.80(a)(1)(§483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environmen development and tran diseases and infection program. The facility must estal	e 69 investigation survey on illed to keep unattended a locked medication cart for s observed (500 hall ducted with the Regional ervices (RDCS) and the 3/23 at 4:53 PM and stated API plan was ineffective for errors and medication stopped auditing and and did not continue to make stayed in compliance. The istrator stated they believed neffective for clean, safe t because they failed to ans that needed repairs. A Control 2)(4)(e)(f) atrol blish and maintain an and control program safe, sanitary and ent and to help prevent the ismission of communicable as. prevention and control blish an infection prevention IPCP) that must include, at	F 8	67		TE	2/20/23
	reporting, investigatin	m for preventing, identifying, g, and controlling infections seases for all residents,					

Facility ID: 923408

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/22/2023 RM APPROVED IO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		345236	B. WING		C 01/20/2023		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP			
ACCORD	US HEALTH AT WILMING	STON		20 WELLINGTON AVENUE VILMINGTON, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	providing services unarrangement based u conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement tha least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact will transmit th (vi)The hand hygiene by staff involved in dir	brs, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify de diseases or can spread to other in possible incidents of the or infections should be assission-based precautions ent spread of infections; dation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the oble for the resident under the s under which the facility ees with a communicable cin lesions from direct to or their food, if direct the disease; and procedures to be followed rect resident contact.	F 880				

Facility ID: 923408

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/22/2023 M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345236	B. WING				C / 20/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
ACCORDI	US HEALTH AT WILMING	GTON			20 WELLINGTON AVENUE /ILMINGTON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E ACTION SHOULD BE COMPLET D TO THE APPROPRIATE DATE		
F 880	transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on staff intervi establish a water mar Legionella and other of pathogens. This had facility residents. The findings included In an interview with th at 10:40 AM he stated water management po other waterborne path In an interview with th 01/11/23 at 1:30 PM h have a water manage Legionella or other op pathogens but the ne facility was sending ir would routinely check and other pathogens. new owner 's policy t	le, store, process, and to prevent the spread of view. ct an annual review of its r program, as necessary. is not met as evidenced iews the facility failed to nagement program for opportunistic waterborne the potential to affect all : ne Administrator on 01/11/23 d the facility did not have a rogram for Legionella or nogens. Ne Maintenance Director on the stated the facility did not ement program for oportunistic waterborne w company who bought the an outside contractor who the water for Legionella He provided a copy of the itled, rne Pathogen Management 1/22. He concluded he	F	880	Directed Plan of Correction F880 Address how corrective action will be accomplished for those residents four have been affected by the deficient practice: The facility is unable to correct that th previous management company did have Legionella testing in place. On 11/1/22 when the facility changed management, the Legionella /Water Borne Pathogen Management Progra was initiated. No specific residents widentified as having been affected by alleged deficient practice. On 1/19/23 Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPI Certified Regional Vice President of Clinical Services regarding the need Legionella and other opportunistic water-borne pathogen testing. Address how the facility will identify or residents having the potential to be affected by the same deficient practice.	e not m ere the the CE for ther e :		

Facility ID: 923408

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HUMAN SERVICES EDICAID SERVICES				FORM): 02/22/2023 1 APPROVED). 0938-0391
X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C	
345236	B. WING				_ 20/2023
		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	
	820 WELLINGTON AVENUE				
ÖN		WI	ILMINGTON, NC 28401		
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	¢			(X5) COMPLETION DATE
72	F 8	880	potential to be affected. Address what measures will be put interplace or systemic changes made to ensure that the deficient practice will need to recur: A root cause analysis determined that of education contributed to non-compliance with Legionella and of opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director we provided a one-to-one educational in-service by the Nursing Home Administrator and SPICE Certified Regional Vice President of Clinical Services regarding the need for Legion and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPIC Certified Regional Vice President of Clinical Services that it is the responsil of the Maintenance Director to overset the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPIC Certified Regional Vice President of Clinical Services that it is the responsil of the Maintenance Director to overset the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPIC Certified Regional Vice President of Clinical Services on the policy for Legionella / Water-Borne Pathogen Program. On 2/13/23 Legionella and other opportunistic water-borne pathogen	ot lack ther was hella E bility	
	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345236 ON EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	EDICAID SERVICES (X2) MULT A. BUILDIN IDENTIFICATION NUMBER: A. BUILDIN 345236 B. WING ON EMENT OF DEFICIENCIES ID PRECEDED BY FULL C IDENTIFYING INFORMATION)	EDICAID SERVICES (X2) MULTIPLE (A. BUILDING) IDENTIFICATION NUMBER: A. BUILDING 345236 B. WING ST 345236 ON ID PRECEDED BY FULL CON ID PREFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	EDICAID SERVICES (1) PROVIDERISUPPLIENCUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345236 B. WING 345236 B. WING ON STREET ADDRESS, CITY, STATE, 2JP CODE 820 WELLINGTON AVENUE WILMINGTON, NC 28401 EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DENTIFYING INFORMATION) D PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFEN DEFICIENCY) 72 F 880 73 F 880 74 Protoclass and the deficient practice will n recur: A root cause analysis determined that of education contributed to non-compliance with Legionella and ot opportunistic water-borne pathogen testing. 01 119/23 the Maintenance Director v provided a one-to-one educational in-service by the Nursing Home Administrator and SPICE Certified Regional Vice President of Clinical Services regarding the need for Legion and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director to overset the Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director to overset the Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPIC Certified Regional Vice President of Clinical Services on the policy for Legionella / Water-Borne Pathogen though an outside company will be conducting the testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPIC	EDICAID SERVICES ONE NOT (1) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: (2) MULTIFILE CONSTRUCTION A BUILDING (3) DATE CON 345236 INVING (2) MULTIFILE CONSTRUCTION A BUILDING (3) DATE CON STREET ADDRESS, CITY, STATE, 2)P CODE S20 WELLINGTON AVENUE WILMINGTON, NC 23401 (1) PROVIDER'S FLAN OF CORRECTION (CARSS AREFURENCE) TO THE APPROPRIATE DEFICIENCY) CON ID PREFIX TAS PROVIDER'S FLAN OF CORRECTION (CARSS AREFURENCE) TO THE APPROPRIATE DEFICIENCY) 2'2 F 880 PROVIDER'S FLAN OF CORRECTION (CARSS AREFURENCE) TO THE APPROPRIATE DEFICIENCY) 2'2 F 880 POTENTIAL DEFICIENCY) 2'2 F 880 POTENTIAL

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/22/2023 MAPPROVEE O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	X2) MULTIPLE CONSTRUCTION A. BUILDING		Сом	E SURVEY PLETED C
		345236	B. WING _				/20/2023
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	CCORDIUS HEALTH AT WILMINGTON			820 WELLINGTON AVENUE			
				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 CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	2.73	F8	380	Incorporated was scheduled for 2/14/2 and every six months. Legionella and other opportunistic water-borne pathogen testing will be conducted on 2/14/23 by Environme Chemist Incorporated. Weekly going forward the Maintenance Director will run water for a minimum of five minutes to ensure there is residual standing water in the pipes. The Governing Body to include the Vie President, the Regional Vice Presider Operations or the Regional Vice Presider Operations or the Regional Vice Presider Operations or the Regional Vice Presider of Clinical Services will review the Wa Flow Audits and results of Legionella other opportunistic water-borne pathot testing during routine visits. Indicate how the facility plans to moni- its performance to make sure that solutions are sustained: Weekly for twelve weeks the Maintena Director will perform documented Wat Flow Tests by running water in empty resident rooms to ensure water flows through the pipes preventing standing water. Weekly for twelve weeks the Nursing Home Administrator (NHA) w randomly audit the Water Flow Tests conducted by the Maintenance Director validate completion and findings. NHA present the result of the weekly audits	ntal e of al / ce tor dent ter and gen tor tor ance er	
					the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three month The Quality Assurance and Performar Improvement Committee will review th results of the audit, making	is. ice	

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	-	D HUMAN SERVICES				FOF	ED: 02/22/202 RM APPROVE <u>O. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		345236	B. WING			0.	U/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT WILMING		820 WELLINGTON AVENUE				
AUCONDI				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	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	. 74	F	880	recommendations as needed, to assi compliance is sustained ongoing. The Governing Body to include the V President, the Regional Vice Preside Operations or the Regional Vice Preside of Clinical Services will review the Wa Flow Audits and results of Legionella other opportunistic water-borne pathot testing during routine visits. The timeline for completion of educat for Legionella and other water-borne pathogen testing is 1/19/23. A root ca analysis determined that lack of educ contributed to non-compliance with Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director provided a one-to-one educational in-service by the SPICE Certified Reg Vice President of Clinical Services regarding the need for Legionella and other opportunistic water-borne pathot testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by SPICE Cert Regional Vice President of Clinical Services that it is the responsibility of Maintenance Director to oversee the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. On 1/19/23 th Maintenance Director was provided a one-to-one educational in-service by SPICE Certified Regional Vice Preside of Clinical Services on the policy for Legionella / Water-Borne Pathogen Program.	ice nt of sident ater and ogen ion ause sation • was gional d ogen tified f the	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/22/2023 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		345236	B. WING			0	C 1/20/2023
NAME OF PF	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	JS HEALTH AT WILMING	TON		82	20 WELLINGTON AVENUE		
ACCORDI				w	/ILMINGTON, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	Continued From page	2 75	F	880	Legionella and other opportunistic water-borne pathogen testing will b conducted on 2/14/23 by Environr Chemist Incorporated. On 2/13/23 Legionella and other opportunistic water-borne pathoger testing by Environmental Chemist Incorporated was scheduled for the every six months. The Governing Body to include the President, the Regional Vice Presic Operations or the Regional Vice Pre- of Clinical Services will review the Legionella and other opportunistic water-borne pathogen testing durin routine visits. On 2/13/23 a Root Cause Analysis completed by the Regional Vice Pre- of Operations, Nursing Home Administrator, Staff Development Coordinator, Director of Nursing an Maintenance Director. The results of Root Cause Analysis revealed the f Maintenance Director lacked a func- understanding of the procedure and program for water safety managem Legionella and other water-borne pathogen testing. The previous management company did not have Legionella testing contract in place. 11/1/22 when the facility changed management, the Legionella /Wate Borne Pathogen Management Prog- was initiated. On 1/19/23 the Maintenance Director	nental facility Vice lent of esident g was esident dent of d of the facility stional d ent for e On r gram	
					provided a one-to-one educational in-service by the Nursing Home		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 02/22/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345236	B. WING				C /20/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
ACCORD	ACCORDIUS HEALTH AT WILMINGTON				20 WELLINGTON AVENUE		
				W	/ILMINGTON, NC 28401		1
(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 F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 880	Continued From page	≥ 76	F	880	Administrator and the SPICE Certified Regional Vice President of Clinical Services regarding the need for Legion and other opportunistic water-borne pathogen testing. I attest that on 1/19/23 I provided the Maintenance Director with a one-to-or educational in-service. I am SPICE Certified an I am the Regional Vice President of Clinical Services for Augu Healthcare. I attest that I educated the Maintenance Director on the need for Legionella and other opportunistic water-borne pathogen testing. I attest on 1/19/23 I provided the Maintenance Director a one-to-one educational in-service to include it is the responsib of the Maintenance Director to overset the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. I attest that on 1/19/23 I provided the Maintenance Director a one-to-one educational in-service to include it is the responsib of the Maintenance Director to overset the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. I attest that on 1/19/23 I provided the Maintenance Director a one-to-one educational in-service on the policy for Legionella. Water-Borne Pathogen Program. On 2/13/23 a Quality Assurance and Performance Improvement Committee was held. Members present include th Nursing Home Administrator, Director Nursing, Maintenance Director, Assist Director of Nursing, Staff Developmen Coordinator, Regional Vice President Operations and Regional Vice President of Clinical Services reviewed the result the root cause analysis. The lab company, Environmental Che	nella le st that illity e illity e of ant t of int ts of	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED				
		345236	B. WING			C / 20/2023			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
				820 WELLINGTON AVENUE					
ACCORDI	US HEALTH AT WILMING	SION		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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 880	Continued From page	₽ 77	F 8	Incorporated is scheduled to test the water for legionella and other water-pathogens on 2/14/23 and every six months thereafter. The QAPI Committee will review the results of the testing upon receipt ar make recommendations accordingly The QAPI Committee will meet mon review the audits for Infection Control the Directed Plan of Correction. The Governing Body to include the V President, the Regional Vice Preside Operations or the Regional Vice Pree of Clinical Services will review the W Flow Audits and results of Legionella other opportunistic water-borne path testing during routine visits.	borne d thly to ol for /ice ent of sident /ater a and				

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