	VT OF HEALTH AND HUMAN SERVICES DR MEDICARE & MEDICAID SERVICES			AH "A" FORM			
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:			
FOR SNFs AND	FOR SNFs AND NFs		B. WING	12/1/2023			
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS,	LITY, STATE, ZIP CODE				
		1804 FOREST H	1804 FOREST HILLS ROAD W				
ACCORDIU	S HEALTH AT WILSON	WILSON, NC	WILSON, NC				
ID PREFIX							
TAG	SUMMARY STATEMENT OF DEFICIENCE	CIES					
F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)						
	 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to 						
	(A) The attending physician.(B) A registered nurse with responsibility for the resident.						
	(C) A nurse aide with responsibility for the resident.						
	(D) A member of food and nutrition services staff.(E) To the extent practicable, the participation of the resident and the resident's representative(s). An						
	(c) for an explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.						
	(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.This REQUIREMENT is not met as evidenced by:						
	Based on record review and staff interviews, the facility failed to update a resident care plan to reflect the resident's current nutritional status for 1 of 26 residents whose care plans were reviewed (Resident #2).						
	The findings included:						
	Resident #2 was admitted to the facility on 3/09/20. Resident #2 was hospitalized on 10/28/23 and returned to the facility on 10/31/23.						
	A physician diet order dated 10/31/23 for a carbohydrate controlled no added salt diet (CCHO/NAS), regular texture, thin consistency, and double protein with meals.						
	The Registered Dietitian (RD) admission assessment dated 10/31/23 revealed his diet was a CCHO/NAS regular texture. The RD recommended continuation of the previous diet order to include double protein with meals.						
	The Minimum Data Set (MDS) admission assessment dated 11/06/23 revealed Resident #2 was cognitively intact. Resident #2 was not coded for a swallowing disorder and was not coded for a mechanically altered diet.						
	Resident #2's care plan last reviewed and revised on 11/29/23 revealed a care plan in place for nutrition risk related to a mechanically altered diet with an intervention to provide and serve diet as ordered.						
	During an interview on 12/01/23 at 9:04 am with MDS Nurse #2 she revealed she was responsible to ensure						

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

The above isolated deficiencies pose no actual harm to the residents

AH

NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM A. BULLDNG:	"A" FOI					
08.887.A0D.NT- 34563 n.WING 12/U SMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STATE, AP CODE 1844 FOREST IILLS ROAD W 12/U D SUMMARY STATEMENT OF DEFICIENCES 15/U D SUMMARY STATEMENT OF DEFICIENCES 15/U F 657 Continue (From Page 1 the accuracy of Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's was entered before the last revision date of the care plan and the care plan should reflect the current order. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information. (1) A facility may not release information that is resident-identifiable to the public. (1) The ficility may release information that is resident-identifiable to the accurative of accuracy (1) Complete; (1) Accurately decemented; (1) Accurately decemented; (1) Accurately decemented; (1) Accurately decemented; (1) Accurately decemented; (1) Accurately decemented; (1) Readily accessible; and (1) Systematically organized §483.70(0) (2) The facility must keep confidential all information contained in the resident's records, regardless of the from or stonege method of the records, except when release is- (1) C	SURVEY					
J45063 R WING 12/U AMU OF PROVIDER OR SLIPPLIER STREET ADDRESS, CTV, STATL, 20 CODE JAME COMPARIANCE ADDRESS, CTV, STATL, 20 CODE JAME COM	'LETE:					
Note of the decision of the secure of the care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. Ar interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The MDS Nurse #2 stated when who reviewed a care plan, she checked the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's and the physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's and the accuracy of Resident #2's care plan. The DON stated the physician order for Resident #2's care plan. V8 42 Resident Records - Identifiable Information CITR(6): 483.20(0/5), 483.70(0/1)-(5) \$483.20(0/5) Seident fiftible information. (i) The facility may not release information that is resident-identifiable to the public. (ii) The facility may not release information that is resident-identifiable to an agent only in accordance with a contract which the agent agrees not to use or disclose the information except to the extent the facility issleft is permitted to do so. \$483.70(0)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is	2023					
CCCORDIUS HEALTH AT WILSON WILSON, NC 0 SUMMARY STATEMENT OF DEFICIENCIES F 657 Continuel From Page 1 the accuracy of Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 ut 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse strene exponsible for the accuracy of Resident #2's and plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2's accuracy of Resident #2's accuracy of Resident #2's accuracy of Resident #2's accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5) Resident-identifiable information. (i) A facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (i) Accurately documented; (ii) Readity accessible; and (iii) Readity accessible; and (v) Systematically organized §483.70(i)(2)						
P P REFRA SUMMARY STATEMENT OF DEFICIENCES F 657 Continued From Page 1 the accuracy of Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physicin orders and would revise the care plan as needed based on the physicin orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall secing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated Physician order for Resident #2's was entered before the last revision date of the care plan and the care plan should reflect the current order. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to the current to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(
PREPARA SUMMARY STATEMENT OF DEFICIENCIES F657 Continued From Page 1 the accuracy of Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2's care plan. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.30(i)(1)-(5) \$483.20(f)(5), Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. \$483.70(i) Medical records. \$483.70(i) Medical records. \$483.70(i) Medical records. \$483.70(i) Medical records. \$483.70(i) Medical records. \$483.70(i) Medical records. <						
 F 657 Continued From Page 1 the accuracy of Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse are seponsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s) 483.20(f)(5), 483.70(i)(1)-(5) F 843 Resident Records - Identifiable Information. (i) A facility may release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i) maccordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are: (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized S483.70(i)(1) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except w						
F842 Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2's care plan. The DON stated the physician order for Resident #2's care plan. The MDS Nurse #2 F842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) \$483.20(f)(5), Resident-identifiable Information. (i) A facility may release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. \$483.70(i)(1) na coordance with accepted professional standards and practices, the facility must maintain medical records. \$483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is: (ii) Readily accessible; and (iii) Readily accessible; and (iv) Systematically organized </td <td></td>						
physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's dimission orders were reviewed during the clinical meeting and the MDS Nurse attended the neeting. The DON stated the physician order for Resident #2's care plan. The DON stated Resident #2's dimission order for Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-(i) Complete; (i) Accurately documented; (iii) Readily accessible; and (ii) Ne facility may release information do the records, except when release is. (i) The facility must meeting. (i) Outplete; (ii) Accurately documented; (iii) Readily accessible; and (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the fo						
stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet. An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2 was entered before the last revision date of the care plan and the care plan should reflect the current order. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(f)(1)-(5) §483.20(f)(5), Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i) In accordance with accepted professional standards and practices, the facility must maintain medical records on cach resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of t						
An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2 was entered before the last revision date of the care plan and the care plan should reflect the current order. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), Resident-identifiable Information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestie violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2 was entered before the last revision date of the care plan and the care plan should reflect the current order.An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan.F 842Resident Records - Identifiable Information CFR(s): 483.20(f)(5), Resident-identifiable to the public.(i) A facility may not release information that is resident-identifiable to the public.(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.§483.70(i) Medical records. §483.70(i) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2 was entered before the last revision date of the care plan and the care plan should reflect the current order.An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan.F 842Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 883.70(i)(1)-(5)§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.§483.70(i) Medical records. §483.70(i)(1) naccordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, research						
DON stated the physician order for Resident #2 was entered before the last revision date of the care plan and the care plan should reflect the current order. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 843.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) na coordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident regresentative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic vio						
the care plan should reflect the current order. An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.306; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ dona						
An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) \$483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. \$483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized \$483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.306; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
was responsible for the accuracy of Resident #2's care plan. F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may not release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research	the care plan should reflect the current order.					
 F 842 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) § 483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may rolease information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. § 483.70(i) Medical records. § 483.70(i) Medical records. § 483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized § 483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)§483.20(f)(5) Resident-identifiable information.(i) A facility may not release information that is resident-identifiable to the public.(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.§483.70(i) Medical records.§483.70(i) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;(ii) Accurately documented;(iii) Readily accessible; and (iv) Systematically organized§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;(ii) Required by Law;(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For ruetment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research 						
164.506;(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research						
purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety						
as permitted by and in compliance with 45 CFR 164.512.						
Event ID: 2H2N11	continuation she					

AH

	OR MEDICARE & MEDICAID SERVICES			AH "A" FORM			
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:			
FOR SNFs AN	D NFs	345063	B. WING	12/1/2023			
NAME OF PRO	DVIDER OR SUPPLIER	STREET ADDRESS, C	CITY, STATE, ZIP CODE	I			
ACCORDI	US HEALTH AT WILSON	1804 FOREST HI WILSON, NC	1804 FOREST HILLS ROAD W WILSON NC				
ID			wilson, ite				
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES						
F 842	Continued From Page 2						
Г 042	\$483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.						
	unautionized use.						
		§483.70(i)(4) Medical records must be retained for-					
	(i) The period of time required by State law; or(ii) Five years from the date of discharge when there is no requirement in State law; or						
		(ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.					
	§483.70(i)(5) The medical record must c	\$483.70(i)(5) The medical record must contain-					
	(i) Sufficient information to identify the resident;						
	(ii) A record of the resident's assessments;						
	(iii) The comprehensive plan of care and services provided;(iv) The results of any preadmission screening and resident review evaluations and determinations conducted						
	(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;						
	(v) Physician's, nurse's, and other licensed professional's progress notes; and						
	(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.						
	This REQUIREMENT is not met as evidenced by: Based on the record review and staff interviews the facility failed to document complete and accurate						
	information in the Medical Administration Record (MAR) for 1 of 26 Residents (Resident #8) whose records were reviewed.						
	Findings included:						
	Resident #8 was admitted to the facility on 8/25/21.						
	A review of physician orders for Resident #8 dated 4/27/23 revealed she had an order for Benadryl Capsule 25 mg (milligrams) 1 capsule by mouth every 6 hours as needed for itching.						
	Review of the Nursing Progress Note for 4/27/23 at 1:11PM signed off by Nurse #1 revealed Benadryl 25 mg was administered for Resident #8.						
	A review of the MAR for 4/27/23 revealed there was no documentation or recording of the Benadryl Capsule 25 mg being administered on the same date at 1:11 PM.						
	During an interview with Unit Manager #1 on $11/29/23$ at 2:24 PM she revealed Nurse #1 administered the medications but failed to document on the MAR the administration of the Benadryl Capsule 25mg on $4/27/23$. She further revealed Nurse #1 no longer worked at the facility.						
	4/27/23. She further revealed Nurse #1 no longer worked at the facility.						
	Attempts to reach Nurse #1 revealed her last known contact phone number was no longer in service.						
	In an interview with the Director of Nurs responsibility of the nurse administering						

	MEDICARE & MEDICAID SERVICES	i		"A" FOR			
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
		345063	B. WING	12/1/2023			
AME OF PROVIDE	ER OR SUPPLIER	STREET ADDRESS, CI	TY, STATE, ZIP CODE	I			
			1804 FOREST HILLS ROAD W				
ACCORDIUS H	EALTH AT WILSON	WILSON, NC	WILSON, NC				
D							
REFIX AG	SUMMARY STATEMENT OF DEFICIEN	ICIES					
F 842	Continued From Page 3						
. 012	C						
	In an interview with the Administrator of	n 11/30/23 at 10:22 AM	she indicated that at a minimum she				
	expected documentation of MAR to refl						

AH