STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Wilson	1804 Forest Hills Road W Wilson, NC 27893

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review and staff and resident interviews, the facility failed to protect a resident's right to be free from misappropriation of property leading to a suspected monetary loss of $3957.55. The deficient practice was for 1 of 3 residents reviewed for misappropriation of resident property (Resident #27). The findings included: Resident #27 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit and cerebral infarction (stroke). Resident #27's quarterly Minimum Data Set (MDS) dated [DATE] indicated he had intact cognition and had no behaviors. A Brief Interview of Mental Status assessment dated [DATE] indicated Resident #27 scored a 09, which indicated moderate cognitive impairment. The facility 24-hour Initial Report dated 5/31/24 documented an allegation that Resident #27 realized funds were missing from his bank account. The Administrator was notified on 5/31/24. The report noted the transactions appeared to have occurred over several months. It was noted Resident #27 had given his automatic teller machine (ATM) debit card to multiple people over time to buy drinks, snacks, and pizza in the past, but saw many additional unapproved withdrawals. There was no physical or mental harm noted. No alleged perpetrator was identified and the local police were notified. The facility Investigation Report dated 6/7/24 documented Resident #27 went to the bank and had three months of statements accessed and felt certain that there were expenditures that were not his. Some of the disputed charges were questionably his as they were from the vending machines he frequents in the facility. The Report noted that during a police interview with the resident, Resident #27 identified a staff member, Nurse Aide (NA) #3, and said he had given her his debit card to pick him up a sandwich at a local sandwich shop but could not remember the day. He said that after she got him a sandwich, he noticed his money was going faster. The Police Department stated they would contact her. NA #3 was suspended pending the results of the investigation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An addendum to the facility investigation dated 6/16/24 written by the Administrator noted the police had notified the facility that individuals had been identified using Resident #27's debit card without authorization and one of the individuals had been arrested. NA #3, who the resident identified to the police, did not appear to be involved as per the police investigation and was taken off of suspension. A police report by Police Officer #1 dated 6/24/24 noted there were three charges to Resident #27's debit card at ATMs on 4/22/24, 5/04/24, and 5/10/24, totaling $1709.00. Multiple other charges were noted in the report were made to various websites not used by Resident #27. Three individuals, NA #1, NA #2, and Individual #1 were identified in the investigation as having been the alleged perpetrators. Individual #1 was charged with identity theft and two counts of obtaining property under false pretenses. NA #2 was also charged with identity theft and six counts of obtaining property under false pretenses for purchases made online. The police report did not specify any charges or actions related to NA #1. In an interview on 3/12/25 at 9:03 AM, the Administrator said NA #1 and NA #2 were contracted NAs from a staffing agency, not facility employees. She said Individual #1 was related to NA #1 and NA #2. She said the total amount taken from Resident #27's bank account was $3957.55. In an interview on 03/12/25 at 9:40 AM, Resident #27 said his debit card went missing but he could not remember any details. He said the Administrator took care of everything for him and kept him informed of the investigation. He said the money had been replaced by the bank. He said he had a lock box and his nightstand drawer locked and he had the key but he preferred to keep his wallet with him at all times to maintain control of it. In an interview on 3/12/25 at 2:54 PM, Unit Manager #1 said she was the Unit Manager on Resident #27's unit. She said Resident #27 confided in her that more money than he spent was being taken out of his bank account. The Unit Manager said she helped Resident #27 obtain his bank statements and file fraud disputes. His bank statements showed multiple purchases that the resident denied making. Some of the websites were stores, and Resident #27 had not received any package deliveries at that time. She said on one occasion, a facility staff member took Resident #27 to run errands and had Individual #1 go with them. Resident #27 told her that Individual #1 helped him take money out of an ATM because he couldn't push the buttons and that Individual #1 punched in his personal identification number (PIN). She said Resident #27 was not distressed and he just wanted to find out what happened and get his money back. In an interview on 3/13/25 at 8:55 AM, the Administrator said neither the facility nor the staffing agency had current contact information for NA #2. Attempts to reach NA#1 were unsuccessful. Attempts to reach Police Officer #1 were unsuccessful during the survey. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/13/25 at 5:38 PM, the Administrator said the facility believed one of the NAs took Resident #27's debit card while working at the facility. They examined timecards for March, April, and May of 2024, and both NA #1 and NA #2 worked at the facility during that time period. She said as a result of the incident, the facility changed their policy on who can assist residents purchasing items and assisting resident with their money and directed staff to speak with the Social Worker, Activities Director, or the Business Office Manager. The policy said that no other staff may handle money or payment cards for the residents at any time. She said the facility sent out messages to all of the families and in-serviced all staff on the change of policy. In an interview on 3/13/25 at 8:09 PM, the Administrator said the facility created a plan of correction but had not completed the intended audits or monitored the corrections in the Quality Assurance committee as indicated in their plan.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50234 Based on record review and staff interviews, the facility failed to report an allegation of misappropriation of resident property to the Department of Social Services (DSS). This deficient practice affected 1 of 3 residents reviewed for misappropriation (Residents #27). The findings included: The facility 24-hour Initial Report dated 5/31/24 completed by the Administrator documented an allegation that Resident #27 realized funds were missing from his bank account. The Administrator was notified on 5/31/24. The report noted the transactions appeared to have occurred over several months. It was noted Resident #27 had given his automatic teller machine (ATM) debit card to multiple people over time to buy drinks, snacks, and pizza in the past, but saw many additional unapproved withdrawals. There was no physical or mental harm noted. No alleged perpetrator was identified and the local police were notified. There was no documentation on the Initial Report that indicated DSS was notified. The Facility Investigation Report dated 6/7/24 completed by the Administrator documented the police were investigating and had suspects in the case. The Facility Investigation Report did not document that DSS was notified of the allegation. An addendum to the facility investigation dated 6/16/24 written by the Administrator noted the police had notified the facility that individuals had been identified using Resident #27's debit card without authorization and one of the individuals had been arrested. In an interview on 3/12/25 at 4:35 PM, the Administrator said she did not remember notifying DSS of the allegation and investigation related to the misappropriation of Resident #27's property, but would check with the Social Worker to see if she notified them. She said she was not aware that DSS had to be notified in addition to the state agency and the local police. In an interview on 3/12/25 at 5:03 PM, the Social Worker said she was involved in the investigation related to the misappropriation of Resident #27's property and DSS was not notified of the allegation.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record review and staff interviews, the facility failed to ensure an updated Preadmission Screening and Resident Review (PASRR) was completed prior to admission for a resident diagnosed with psychosis and depression for 1 of 2 sampled residents reviewed for PASRR (Resident #32). The findings included: The North Carolina Department of Health and Human Services (NCDHHS) PASRR determination letter dated 09/30/2017 for Resident #32 revealed a level I screen and a PASRR number that remained valid for the individual's stay and no further PASRR screening was required unless a significant change occurred with the individual's status which suggested a diagnosis of mental illness. Resident #32 was admitted to the facility on [DATE] with diagnoses including psychosis not due to a substance or known physiological condition and depression. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #32 was cognitively intact, was not evaluated by Level II PASRR and determined to have a serious mental illness, and had diagnoses of depression and psychotic disorder. The MDS indicated she had not had any behaviors or rejection of care in the assessment period and had taken antipsychotic and antidepressant medications. In an interview on 3/13/25 at 2:57 PM, the Social Services Director said the social services office, which included herself and two assistants, were responsible for ensuring a PASRR was completed prior to admission. She said she did not realize Resident #32's PASRR had not been done since 2017. She had looked through the facility files upon surveyor request for a PASRR completed after that date, but because the hospital had not sent one, she was unable to find a more recent PASRR. She said the social services office should have made sure a Level 1 assessment was done if they did not receive one from the hospital. In an interview on 3/13/25 at 5:38 PM, the Administrator stated Resident #32 had a negative PASRR level I screen (a negative level I screen permits facility admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later) from 2017. She said the social services department was responsible for ensuring PASRR information was completed.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on observation, record review, and interviews with a resident and staff, the facility failed to provide double portions as ordered by the physician and to ensure a surgeon's recommendation for a high protein diet was implemented following a surgical amputation of the resident's foot for 1 of 6 residents reviewed for therapeutic diets (Resident #56). The findings included: a. Resident #56 admitted to the facility on [DATE]. Resident #56's comprehensive care plan initiated on 1/29/25 documented he had potential for a nutritional problem related to diagnoses of hypertension (high blood pressure), peripheral vascular disease, congestive heart failure, and type 2 diabetes mellitus, atherosclerotic heart disease, anticoagulant use, and a therapeutic diet. Interventions included to provide and serve his diet as ordered. Resident #56's physician's orders dated 1/30/25 noted he was to receive a diet of Controlled Carbohydrates and No Added Salt diet with double portions at breakfast. A significant change Minimum Data Set (MDS) dated [DATE] indicated Resident #56 was cognitively intact, fed himself after staff set-up assistance with meals, and received a therapeutic diet. Review of the facility's Diet Order Report dated 3/12/25 recorded Resident #56 was to receive a double portions at breakfast. An observation on 3/13/25 at 8:48 AM revealed Resident #56 with his breakfast tray. His breakfast meal had one sausage patty, two pancakes, and a 4-ounce bowl of grits. The diet slip on his tray indicated he was to receive double portions with breakfast. Double portions were not observed. In an interview on 3/13/25 at 8:49 AM, Resident #56 said he received one patty of sausage, two pancakes, and a small bowl of grits. He said he ate the grits but did not want to eat any more of his breakfast because his family would be bringing him restaurant food. In an interview on 3/13/25 at 3:14 PM, the Registered Dietitian (RD) said that Resident #56 should have received a double portion of the breakfast foods as ordered because the calories would assist with wound healing. In an interview on 3/13/25 at 4:11 PM, the Dietary Manager (DM) said that a resident with a diet order for double portions should receive double portions of meats, starches, and vegetables. He said Resident #56 should have received two sausage patties and a larger bowl of grits. The DM stated that it was an oversight that Resident #56 did not receive double portions at breakfast. In an interview on 3/13/25 at 5:05 PM, the facility Nurse Practitioner (NP) said Resident #56 had an order for double portions for his wound healing. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #56 was admitted to the facility on [DATE] with diagnoses including non-pressure chronic ulcer of right foot, gangrene, peripheral vascular disease, osteomyelitis (an infection in the bone) of ankle and foot, hypertension (high blood pressure), congestive heart failure, atherosclerotic heart disease and type 2 diabetes mellitus with circulatory complications. A Wound Nurse Practitioner progress note dated 2/19/25 documented Resident #56 was scheduled to have part of his right foot amputated that day. A significant change Minimum Data Set (MDS) dated [DATE] indicated Resident #56 was cognitively intact, fed himself after staff set-up assistance with meals, he had a recent surgery which required skilled nursing care, received a therapeutic diet, and received anticoagulants (medications that thin the blood to prevent blood clots). Resident #56's handwritten surgical consultation note dated 2/26/25 indicated he had a right foot transmetatarsal (the front part of the foot including the toes) amputation for dry gangrene on 2/19/25. The note included orders for antibiotics and wound care. The handwritten note did not include recommendations regarding Resident #56's diet. Resident #56's typewritten surgical consultation report dated 2/26/25 noted the same information as was noted on the handwritten note. The typewritten report also included he should be eating a diet high in protein to aide in the healing of the surgery site. Resident #56's nursing progress notes written by Unit Manager #1 dated 2/26/25 noted his visit with the surgeon but did not address the surgeon's recommendation for a high protein diet. Resident #56's comprehensive care plan updated 3/01/25 documented he had potential for a nutritional problem related to diagnoses of hypertension, peripheral vascular disease, congestive heart failure, type 2 diabetes mellitus, atherosclerotic heart disease, anticoagulant use, and a therapeutic diet. Resident #56's laboratory results dated [DATE] noted his albumin level was 2.9 gm/dl (normal range 3.5 to 5. 5, low albumin levels can affect wound healing). Resident #56's Registered Dietitian (RD) progress note dated 3/12/25 documented Resident #56's diet order was controlled carbohydrates, no added salt, and regular texture. The RD noted Resident #56's food intake was 0-100% in the 7 days prior. She noted he had a pressure ulcer on his right heel. The RD recommended a multivitamin daily to aid with skin integrity. Resident #56's February and March 2025 physician's orders did not reveal orders for a high protein diet or for protein supplements. Resident #56's February and March 2025 Medication Administration Records (MAR) did not contain entries for protein supplementation. In an interview on 3/13/25 at 8:49 AM, Resident #56 said he did not receive any protein supplements such as an additional cup of liquids with medications or a protein milkshake. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/12/25 at 2:54 PM, Unit Manager #1 reviewed Resident #56's orders and said he did not have any orders for a high protein diet or for protein supplements. She said when she reviewed the initial surgeon's consultation notes, she did not see the protein recommendation. She said she would check with medical records to see if there was another note from the physician. During a follow up interview on 3/13/25 at 10:26 AM, Unit Manager #1 stated when Resident #56 returned from his follow up visit with the surgeon on 2/26/25, she reviewed a handwritten progress note from the surgeon which did not include the recommendation for a high protein diet. During the interview, she reviewed the typewritten surgery consultation report dated 2/26/25 with the high protein diet recommendation. She said when a resident saw an outside consultant provider, the provider would sometimes send the facility two notes, a handwritten one done immediately while the resident was at the clinic and another one, usually when information was dictated, that would be faxed to the facility for the chart. The high protein diet recommendation was faxed over from the surgeon on 2/27/25 and she did not see it. She said the Medical Records Coordinator would receive any additional typewritten notes from a provider and upload the notes to the chart. She said she did not normally see the typewritten notes and said she did not know the notes could contain different or additional information. She said a high protein diet would help with Resident #56's wound healing but the recommendation was just missed because it was not on the original handwritten note. Unit Manager #1 reviewed Resident #56's physician orders and said there were no protein supplements ordered and there were no changes to his diet order since 1/30/25 when the double portions with breakfast was ordered. She said the facility had multiple supplements that could have been added to Resident #56's regimen but had not been ordered. In an interview on 3/13/25 at 3:14 PM, the RD said if diet changes were made at an outside consultant appointment, she would be made aware by nursing or when the report was put into the resident's clinical record. She said she had not reviewed the surgeon's progress notes from the 2/26/25 visit and was not sure if it was uploaded into the chart when she reviewed his chart on 3/12/25. She said she did not know about the recommendation for a high protein diet. She said she did not want to comment on Resident #56's specific case re: protein and if it was beneficial for him because she did not remember the details. She saw Resident #56 the day he went out for surgery but did not have another note until 3/12/25. In an interview on 3/13/25 at 4:08 PM, the Director of Nursing (DON) said Resident #56 received double portions of breakfast but she was not aware of the recommendation of a high protein diet from the surgeon. In an interview on 3/13/25 at 4:34 PM, Nurse Practitioner #1 said she was not aware of the recommendation from the surgeon until 3/13/25. She said having Resident #56 on a high protein diet would be a proactive intervention to aide in long-term wound healing. She indicated Resident #56 did not eat much of the facility food but that his family frequently brought in food for him which he ate. She added that the resident's albumin level had increased, indicating he was getting enough protein.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on observations and staff interviews, the facility failed to discard expired food items stored for use in 1 of 1 walk-in refrigerator and failed to serve a hot food item at a safe temperature range (at or above 135 degrees Fahrenheit) to prevent the potential for food borne illness for 1 of 1 meal observations. These practices had the potential to affect food served to residents. The findings included: 1. Observation on [DATE] at 10:47 AM of the walk-in refrigerator revealed 10 yogurt containers with an expiration date of [DATE] on the shelf. In an interview on [DATE] at 10:48 AM, the Dietary Manager (DM) said he had just put the yogurt containers on the shelf in order to take them to the halls for the residents but confirmed they were expired. He said normally the person putting away the delivery each week would check, and he (the DM) would double check dates throughout the week but just missed the yogurt. Observation on [DATE] at 3:10 PM of the walk-in refrigerator revealed two 5-pound tubs of sour cream and two 32 ounce containers of yogurt on the shelf. One tub of the sour cream had been open and used. The manufacturer's label on the sour cream read, Best if used by [DATE] and a label on the top with handwritten dates for the two tubs to be used [DATE] and [DATE]. The two 32-ounce tubs of yogurt were unopened with an expiration date [DATE] with a handwritten date of [DATE] on the lid. In an interview on [DATE] at 4:11 PM, the DM stated the sour cream had a best if used by date, which was not an expiration date, and the label date of [DATE] was the date it was opened. He said they were out of date and should have been removed. He said the handwritten date on the yogurt lid was the day it was delivered from the food distributor. He was not sure why the expiration date was not verified when the yogurt was delivered. 2. Observation on [DATE] at 12:17 PM revealed [NAME] #1 take the temperature of a pan of mashed potatoes on the steam table using a digital thermometer. The temperature of the potatoes was 111 degrees Fahrenheit (F). [NAME] #1 then stirred the mashed potatoes and took the temperature again. The temperature was 113 degrees F. In an interview on [DATE] at 12:18 PM, [NAME] #1 said the mashed potatoes should have maintained a temperature of at least 145 degrees F while on the steam table. In an interview on [DATE] at 12:19 PM, the DM told [NAME] #1 the mashed potatoes needed to be removed from the steam table and heated to temperature. In a continuous observation on [DATE] from 12:19 PM to 12:25 PM revealed [NAME] #1 begin to plate food items for service. The pan of mashed potatoes had not been removed from the steam table to reheat but had not been plated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 12:25 PM, [NAME] #1 scooped mashed potatoes onto a plate for service from the same pan. She continued to plate a puree diet plate and handed it to the dietary aide for service. After surveyor intervention, the plate was not served. The DM asked [NAME] #1 to get a spoon and stir the potatoes and retake the temperature. Observation on [DATE] at 12:26 PM, [NAME] #1 removed the pan of mashed potatoes from the steam table, stirred them, and retook the temperature, which read 122 degrees F. [NAME] #1 continued to stir the potatoes and at 12:27 PM, she retook the temperature, which read 127 degrees F. The DM got a large pot of boiling water to reheat the potatoes. Observation on [DATE] at 12:28 PM, [NAME] #1 stirred the mashed potatoes and took the temperature. The temperature was 141 degrees F. The mashed potatoes were returned to the steam table for service and service resumed. In an interview on [DATE] at 12:28 PM, [NAME] #1 said she did not remove the pan of mashed potatoes when it was not at holding temperature because she didn't think about it. In an interview on [DATE] at 1:10 PM, the DM said the mashed potatoes should have been removed from the tray line when the temperature was too low to be cooked longer before serving to the residents.