STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Rose Manor LLC	4230 North Roxboro Street Durham, NC 27704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on staff and Nurse Practitioner (NP) interviews and record review, the facility failed to ensure a resident's code status information was consistent throughout the medical record for 1 of 2 residents reviewed for advanced directives (Resident #43). The findings included: Resident #43 was admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of the right lung (lung cancer), secondary malignant neoplasm of the brain (when a cancer that started somewhere else in the body has spread to the brain), cerebral edema (brain swelling caused by an abnormal buildup of fluid in the brain's tissues), and seizure disorder. The electronic medical record (EMR) profile indicated Resident #43's code status as Do Not Resuscitate (DNR). Review of Resident #43's EMR revealed a signed Advance Directive form dated 3/8/24 which indicated no code (DNR) status. Review of Resident #43's physician orders dated 3/12/24 revealed he had an order for Do Not Resuscitate (DNR). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #43 was cognitively intact. Further review of Resident #43's EMR revealed a signed Medical Orders for Scope of Treatment (MOST) form dated 4/17/25 which indicated attempt resuscitation. An interview was conducted on 5/6/25 at 11:57 AM with the Social Worker (SW). She stated when she spoke to Resident #43 on 4/17/25 he stated he wanted to be a full code (receive cardiopulmonary resuscitation). She stated Resident #43 understood the difference between full code and DNR status. She further stated she spent approximately 1 1/2 hours reviewing the MOST form and he changed his code status from DNR to full code. The SW stated she took the signed MOST form to the Admission Director, but did not verbally notify anyone about the change in his code status. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/6/25 at 2:39 PM with the Admissions Director. She stated the facility completed an audit of advance directives in April 2025. The Admissions Director and SW divided the residents into 2 teams to review those residents who were missing MOST forms in their EMR. The Admissions Director stated any changes made to a resident's code status should have been communicated to the Director of Nursing (DON) immediately, who in turn changed the code status in the EMR system and notified the Unit Manager of the resident's hall. The MOST form for Resident #43 indicating a change in his code status may have been missed during the audit. An interview was conducted on 5/6/25 at 2:33 PM with the Director of Nursing (DON). She stated if a resident made a change to their code status, the person who was notified of the change in code status was supposed to notify the DON or the Unit Manager immediately. A nurse and a witness would discuss this change in code status with the resident and confirm the change. The Nurse Practitioner would be notified and an order for the new code status would be obtained. The DON further stated that on 5/6/25 once she was notified of the discrepancy in code status, she spoke to Resident #43 confirming full code status and notified the Nurse Practitioner. An interview was conducted on 5/7/25 at 10:29 AM with the Nurse Practitioner (NP). She stated that she typically was notified in a resident's change in code status by the staff member who spoke to the resident and/or family member, such as the DON, Unit Manager, or SW. She further stated she did not update the EMR to the new code status, but gave a verbal order to change code status and would sign the MOST form. An interview was conducted on 5/6/25 at 2:45 PM with the Administrator. He stated it was his expectation for staff to follow the change in code status process for the facility. Any changes in code status should be communicated with nursing and the SW. The Unit Managers and DON conducted daily clinical meetings and changes should be communicated during that time.

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on observations and staff interviews, the facility failed to provide maintenance to the following areas in resident rooms: missing and scraped paint to the doorway and bathroom door (room [ROOM NUMBER]), paint scraped from the walls (Rooms #068 and #074), maintain a clean wall from a red splattered substance (room [ROOM NUMBER]), and the bathroom sink free from buildup (room [ROOM NUMBER]) for 3 of 7 resident rooms reviewed for environment on 1 of 4 halls. The findings included: a. Observation of Resident room [ROOM NUMBER] on 5/5/25 at 11:42 AM revealed scuff marks and missing paint on both sides of the doorway entering the bathroom. The surface of the bathroom door facing inside the bathroom revealed scraped paint approximately 3 inches in height across the length of the bathroom door, exposing what appeared to be a wood-like color underneath. The bathroom sink interior basin was observed to have a light black colored film halfway up from the bottom surface of the sink. b. Observation of Resident room [ROOM NUMBER] on 5/5/25 at 11:47 AM revealed a linear area approximately 25 inches in length and 10 inches in width of scraped paint on the right wall upon entering the room. There was an additional area of scraped paint halfway up the wall behind the headboard measuring approximately 15 inches in length and 6 inches in width. c. Observation of Resident room [ROOM NUMBER] on 5/5/25 at 2:35 PM revealed the wall at the foot of bed A had a linear area of scraped paint approximately 40 inches in length and 5 inches in width. The wall next to the closet door had an area of approximately 10 inches in diameter of a white material where it appeared damage to the wall had been repaired but remained unpainted. The area around the upper part of the bathroom mirror had an area of exposed, crumbling dry wall measuring approximately 8 inches in width and 24 inches in length. There was a red splattered substance approximately 6 inches in length and 2 inches in width on the wall at the foot of bed A approximately 20 inches from the floor. An interview and observation were conducted with the Maintenance Director on 05/07/25 at 12:04 PM. Observations were conducted of rooms #066, #068, and #074. The observations conducted on 05/07/25 at 12:04 PM revealed the same issues discovered on 5/5/25. The Maintenance Director stated since he started in his current position in August 2024, the maintenance department had been in the process of redoing/painting resident rooms. He stated they had completed 7 rooms to date. He further stated some residents do not like them in their rooms so that slows the process down, as work cannot be done while the residents are in their room. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview and observation were conducted with the Housekeeping Manager on 5/7/25 at 12:15 PM. Observations were conducted of room [ROOM NUMBER] and #074. The observations conducted on 05/07/25 at 12:04 PM revealed the same issues discovered on 5/5/25. She stated staff did a general cleaning of resident rooms each morning and rechecked each room again in the afternoon. The facility had a cleaning schedule which included specific cleaning tasks that were done on specific days. The housekeeping manager attempted to remove the light black colored film in the sink in Resident room [ROOM NUMBER] with water and a paper towel and could not. She stated the housekeeping staff would need to use a pumice stone to remove the film. Regarding the splatter on the wall in Resident room [ROOM NUMBER], she stated it would be taken care of right away. Work history reports dated November 2024 through May 2025 were reviewed. There were no entries found for repairs in Resident Rooms #066, #068, and #074. In an interview with the Administrator on 5/8/25 at 2:03 PM he stated there was a process for cleaning and he expected that process to be followed. He further stated staff had been working to improve the facility and the goal was to complete more resident rooms. He stated the facility had to prioritize the work that was needed to be completed, as they had to attend to other major repair issues that have come up.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review, and staff and resident interviews, the facility failed to implement their abuse policy in the area of reporting and investigating. When there was an allegation of abuse the Administrator was not immediately notified (Resident #32 and Resident #331) and an investigation was not initiated at the time of the allegation (Resident #331) for 2 of 3 residents reviewed for abuse. Findings included: 1. Review of the facility policy entitled Prohibition of Abuse Administration, dated 12/24/21 revealed anyone who has any knowledge of abuse should report immediately to their immediate supervisor. All violations will be reported to the State agency within two hours if there is an allegation of abuse. Resident #32 was admitted to the facility on [DATE]. Resident #32's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact with no behaviors. Review of a facility reported incident initial report completed by the Administrator dated 3/11/25 revealed on 3/10/25 at 1:30 AM Resident #32 stated Nurse Aide #5 struck him with a washcloth. The incident report revealed the Administrator was made aware of the incident on 3/11/25 at 7:15 AM. The Administrator notified the local Adult Protective Services on 3/11/25 at 8:30 AM, local law enforcement on 3/11/25 at 8:45 AM and the State agency on 3/11/25 at 8:17 AM. Review of the facility investigation revealed a statement written by Nurse Aide (NA) #6 who stated Resident #32 told her NA #5 struck him after supper on 3/10/25. She reported this disclosure occurred on 3/10/25 at 11:45 PM. A telephone interview was conducted with NA #6 on 5/8/24 at 8:26 AM who stated she informed Nurse #3 on 3/10/25 at approximately 11:50 PM that Resident #32 had stated he was struck by NA #5. NA #6 stated she also wrote a statement. During a telephone interview with Nurse #3 on 5/8/24 at 8:30 AM stated she was never made aware that Resident #32 was struck by NA #5. A telephone interview was conducted with Nurse #4 on 5/7/25 at 3:11 PM. She stated she was advised on 3/10/25 at 11:59 PM by NA #6 that Resident #32 had stated he was struck by NA #5. Nurse #4 stated she heard NA #6 tell Nurse #3. She reported she was not Resident #32's nurse and she believed Nurse #3 reported the incident. An interview was conducted with Resident #32 on 5/6/25 who reported he never stated Nurse Aide #5 struck him. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with Nurse #2 on 5/7/25 at 3:17 PM she stated she reported the allegation of abuse at 7:15 AM on 3/11/25 to the Administrator. She stated she contacted the Administrator when she was made aware of the allegations. Nurse #2 stated she wanted to ensure the allegations were reported. An interview was conducted with the Administrator on 5/8/25 at 10:15 AM. He stated he contacted local Adult Protective Services, law enforcement and the State agency within 2 hours of his notification of the incident. He further stated the allegations should have been reported to him or another manager when NA #6 was told by Resident #32 he had been struck by NA #5. 43222 2. Resident #331 was admitted to the facility on [DATE] and left against medical advice (AMA) on 11/12/24. Review of the 5-day Medicare Minimum Data Set (MDS) assessment revealed that Resident #331 was cognitively intact with adequate hearing/vision, clear speech, and understood/understands. A telephone interview was conducted with Resident #331 on 5/05/25 at 1:03 PM. He revealed that a female staff member (name unknown) came into his room on either 11/5/24 or 11/7/24 walked towards his bed near the window, groped his groin area over his clothing, and walked out while another female staff member (name unknown) stood at the doorway. Resident #331 stated that he did not notify anyone at the facility; however, he told Adult Protective Services (APS) when they visited his home after discharge (date unknown) because no one would believe him. He reported the alleged sexual abuse to the police department himself on 11/25/24. The Police Investigator assigned to Resident #331's case was interviewed via telephone on 5/06/25 at 12:52 PM. She revealed that the report was made on 11/25/24, and the date of the incident occurred either on 11/5/24 or 11/7/24. Resident #331 seemed confused because he forgot who the accused staff member was exactly; however, he described the alleged perpetrator as a black female, 5 foot 7 inches in height, and walked with a limp. The Police Investigator stated that she tried to reach the Administrator by phone but was unsuccessful. When she visited the facility on 1/14/25, the Administrator was away at a conference, so she spoke to the Social Worker Director. The Police Investigator provided a description of the alleged perpetrator, but the Social Worker Director told her that no staff member was a match. The case was inactivated on 1/14/25 due to lack of sufficient evidence. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Worker Director on 5/06/25 at 1:11 PM. She revealed that the Police Investigator and maybe an APS representative visited the facility on 1/14/25 and asked her if she recalled Resident #331 and how he had been discharged . She was also asked about any concerns with nonconsensual touching, but she could not recall Resident #331 ever saying that he was inappropriately touched. The Police Investigator provided a description of the alleged perpetrator, but the Social Worker Director told her that the facility did not have a staff member employed at the facility described by Resident #331. The Social Worker Director stated that she could not recall if the Police Investigator was looking for the Administrator but rather was at the facility to speak to her. She indicated that she did not report the Police Investigator's visit to anyone at the facility because there was not a specific person identified, and Resident #331 was often confused. The Social Worker Director recalled that Resident #331 often complained about his hospital experience, and she thought he referenced a hospital staff member. She stated that she was trained to report all abuse allegations to the Administrator. During an interview with the Director of Nursing (DON) on 5/08/25 at 12:42 PM, she revealed that she was not aware of the sexual abuse allegation made by Resident #331 until it was reported by the state on 5/06/25. However, an investigation was initiated immediately thereafter. The DON stated all abuse allegations should be reported to either the DON and/or the Administrator. The Administrator was interviewed on 5/08/25 at 3:53 PM. He revealed that he should have been notified immediately of the newly reported sexual abuse allegation by Resident #331 on 1/14/25, so that he could follow the abuse policy and procedures and report to the appropriate authorities. The Administrator stated that he would be the one to determine how to move forward with any abuse allegation, not the Social Worker Director.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of falls, gradual dose reduction (GDR), and diagnoses for 4 of 24 residents (Resident #7, Resident #9, Resident #44, and Resident #57) whose MDS assessments were reviewed. 1. Resident #7 was admitted to the facility on [DATE] with diagnoses that included falls, fracture of left radius, generalized muscle weakness, and abnormalities of gait and mobility. Review of Resident #7's progress notes revealed she sustained a fall with no injury on 10/15/24. Resident #7's care plan dated 10/15/24 revealed a focus for falls. Resident #7's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and was not coded for falls. During an interview on 5/7/25 at 2:45 PM with the MDS Coordinator, she stated when updating the MDS she reviewed the fall risk section of a resident's record. She further stated that Resident #7's MDS should have been updated and coded for falls. In an interview with the Director of Nursing (DON) on 5/7/25 at 3:13 PM she stated her expectation was that the MDS should be done timely and coded accurately. She further stated Resident #7's MDS assessment should have been coded correctly for falls. 43222 2. Resident #9 was readmitted to the facility on [DATE] with a diagnosis including paranoid schizophrenia. A physician order dated 3/26/25 revealed Resident #9 received Quetiapine Fumarate (an antipsychotic medication used to treat they symptoms of schizophrenia) oral tablet 100 milligrams (mg) two times a day related to paranoid schizophrenia. Review of Resident #9's significant change MDS assessment dated [DATE] revealed the resident was coded as not receiving an antipsychotic. An interview was conducted with the MDS Nurse on 5/07/25 at 2:20 PM. She revealed she coded Resident #9 as receiving an antipsychotic 7 out of the 7 days during the review period. However, she did not notice that she had chosen no to the section of antipsychotic related to the gradual dose reduction (GDR) questions. The MDS Nurse stated she had missed this detail because she was the only MDS nurse for the last 2.5 years while the facility was looking for a new hire, and all the MDS activity was solely her responsibility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Psychiatric Nurse Practitioner (NP)#1 was interviewed on 5/08/25 at 10:11 AM. She revealed that Resident #9 received an antipsychotic to manage his symptoms and behaviors related to paranoid schizophrenia. During an interview with the Director of Nursing (DON) on 5/08/25 at 12:39 PM, she revealed that the MDS Nurse should have reviewed Resident #9's medical record to ensure the resident received an antipsychotic and code the MDS assessment accordingly. The Administrator was interviewed on 5/08/25 at 3:48 PM. He revealed that the MDS nurse should have coded Resident #9's MDS correctly related to receiving an antipsychotic. However, the interdisciplinary team (IDT) should have completed a final review of the assessment. 3. Resident #44 was readmitted to the facility on [DATE] with a diagnosis including stroke. A physician order dated 12/31/24 revealed Resident #44 received Risperdal tablet 0.5 mg daily in the afternoon for bipolar disorder. Review of Resident #44's annual Minimun Data Set (MDS) assessment dated [DATE] revealed the resident was coded as receiving an antipsychotic without a GDR attempted and the physician did not document a GDR as clinically contraindicated. A psychiatry follow up note dated 3/3/25 completed by Psychiatric Nurse Practitioner (NP) #1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal. An interview was conducted with the MDS Nurse on 5/07/25 at 2:20 PM. She revealed that she coded Resident #44 as receiving an antipsychotic, but she did not notice that a GDR was documented as clinically contraindicated by Psychiatric NP #1 in her note dated 3/3/25. The MDS Nurse stated she was the only MDS nurse for the last 2.5 years while the facility was looking for a new hire, and all the MDS activity was solely her responsibility. During an interview with the Director of Nursing (DON) on 5/08/25 at 12:39 PM, she revealed that the MDS nurse should have reviewed Resident #44's medical record to see if a GDR had been attempted before completing the MDS assessment. GDRs were also included in pharmacy recommendations, which the DON reviewed herself and all that information was uploaded to the resident's medical record. The Administrator was interviewed on 5/08/25 at 3:48 PM. He revealed that the MDS nurse should have identified the documentation in Resident #44's medical record that included a GDR as clinically contraindicated. However, the interdisciplinary team (IDT) should have completed a final review. 4. Resident #57 was admitted to the facility on [DATE] with a diagnosis including schizoaffective disorder. A physician order dated 4/17/25 revealed Resident #44 received Risperdal tablet 0.5 mg daily for schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #57's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was coded as receiving an antipsychotic without a GDR attempted and the physician did not document a GDR as clinically contraindicated. A psychiatry follow up note dated 2/21/25 completed by Psychiatric NP #3 revealed that Resident #44 had a diagnosis of schizoaffective disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal. An interview was conducted with the MDS Nurse on 5/07/25 at 2:20 PM. She revealed that she coded Resident #57 as receiving an antipsychotic, but she did not notice that a GDR was documented as clinically contraindicated by Psychiatric NP #3 in her note dated 2/21/25. The MDS Nurse stated she was the only MDS nurse for the last 2.5 years while the facility was looking for a new hire, and all the MDS activity was solely her responsibility. During an interview with the Director of Nursing (DON) on 5/08/25 at 12:39 PM, she revealed that the MDS nurse should have reviewed Resident #57's medical record to see if a GDR had been attempted before completing the MDS assessment. GDRs were also included in pharmacy recommendations, which the DON reviewed herself and all that information was uploaded to the resident's medical record. The Administrator was interviewed on 5/08/25 at 3:48 PM. He revealed that the MDS nurse should have identified the documentation in Resident #57's medical record that included a GDR as clinically contraindicated. However, the interdisciplinary team (IDT) should have completed a final review.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II referral was resubmitted after a resident was given a new mental health diagnosis for 1 of 2 residents (Resident #44) reviewed for PASRR. The findings include: Review of Resident #44's medical record revealed the resident was originally admitted to the facility on [DATE] and a PASRR level I was completed. She qualified for PASRR level II that was halted on 11/8/24. The resident was diagnosed with depression upon admission and when readmitted on [DATE] was diagnosed with bipolar disorder. Review of physician orders for Resident #44 revealed that Psychiatric Nurse Practitioner (NP)#2 ordered Risperdal (an antipsychotic medication) 0.5 milligrams (mg) 1 tablet in the afternoon on 12/31/24 for bipolar disorder. A psychiatry follow up assessment dated [DATE] completed by Psychiatric NP #1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic medication. Review of Resident #44's most recent comprehensive Minimum Data Set (MDS) dated [DATE] revealed the resident was coded for a level II PASRR and received antipsychotic medication on a routine basis. Psychiatric NP #2 was interviewed via telephone on 5/08/25 at 11:02 AM. He revealed that since Resident #44 had a previous depression diagnosis and was fairly young, he stated that she was misdiagnosed as unipolar and then correctly diagnosed her as bipolar on 12/31/24. An interview was conducted with the Director of Nursing (DON) on 5/08/25 at 3:43 PM. She revealed that if she had been notified when Resident #44 was diagnosed with bipolar disorder on 12/31/2 4, she would have notified the Social Worker Director, who would have then initiated the PASRR II resubmission for a significant change. The Administrator was interviewed on 5/08/25 at 3:52 PM. He revealed that when a resident was given a new mental illness diagnosis or a significant change occurred, a new PASRR II submission would be required. However, The Administrator stated that he was not notified of Resident #44's newly diagnosed bipolar disorder on 12/31/24. If he had been, he would have ensured the resubmission was done in a timely manner.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Rose Manor LLC	4230 North Roxboro Street Durham, NC 27704

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on record review and staff interviews, the facility failed to revise care plans in the areas of antipsychotic use, and a new mental illness diagnosis for 1 of 24 residents (Resident #44) whose comprehensive care plans were reviewed. The findings included: Resident #44 was readmitted to the facility on [DATE] with diagnoses including stroke and depression. A physician order dated 12/31/24 revealed Resident #44 received Risperdal antipsychotic tablet 0.5 milligrams (mg) daily in the afternoon for bipolar disorder. A psychiatry follow up note dated 3/3/25 completed by Psychiatric Nurse Practitioner (NP)#1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal. Review of Resident #44's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was coded as receiving an antipsychotic without a gradual dose reduction (GDR) attempted and the physician did not document a GDR as clinically contraindicated. Review of Resident #44's care plan revealed no revision was made to address the use of Risperdal and the diagnosis of bipolar disorder that was identified on 12/31/24. The MDS Nurse was interviewed on 5/7/25 at 2:17 PM. She revealed that there should have been a care plan for the antipsychotic medication and the diagnosis associated with the physician order, which was bipolar disorder. The MDS Nurse stated that the care plan for both Risperdal and bipolar disorder were not added because she was never notified about the new diagnosis or the addition of an antipsychotic. During an interview with the Director of Nursing (DON) on 5/8/25 at 12:33 PM, she revealed that she would expect that the bipolar disorder and Risperdal were included in Resident #44's care plan when initiated. The care plans were given a final review by the MDS Nurse, so it would have been her responsibility. An interview was conducted with the Administrator 5/8/25 at 3:54 PM. He stated that Resident #44's care plan should have included bipolar disorder and Risperdal. Unfortunately, there was a breakdown of communication, and the appropriate departments were not aware of the new diagnosis.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on record review, staff interviews and Nurse Practitioner (NP) interviews, the facility failed to provide supportive documentation of a newly diagnosed mental illness associated with a newly ordered antipsychotic for 1 of 5 residents reviewed for unnecessary medications. The findings included: Resident #44 was readmitted to the facility on [DATE] with a diagnosis including stroke and depression. A psychiatry follow up assessment dated [DATE] completed by Psychiatric NP #2 revealed that Resident #44 was seen for a follow-up assessment due to depression per the facility's request. She was experiencing auditory hallucinations in the evening confirmed by staff and the resident. The note read in part: Continue Risperdal for auditory hallucinations. Monitor as patient is taking Risperdal which can affect morbidity mortality. Documentation did not include the newly diagnosed bipolar disorder or supportive evaluation of how the bipolar disorder (BPD) diagnosis was determined. A physician order dated 12/31/24 revealed Resident #44 received Risperdal tablet 0.5 milligrams (mg) daily in the afternoon for bipolar disorder entered by Psychiatric Nurse Practitioner (NP) #2. Psychiatric NP #2 was interviewed via telephone on 5/08/25 at 11:02 AM. He revealed that since Resident #44 had a previous depression diagnosis and was young, she was misdiagnosed as unipolar and then correctly diagnosed as bipolar on 12/31/24. Psychiatric NP #2 stated that some patients, such as Resident #44, get diagnosed with depression and then hallucinate or become manic or wander, etc. She was having auditory hallucinations when he assessed her on 12/31/24. Psychiatric NP #2 indicated that provisional diagnoses could take up to 6 months, and medications were prescribed before a diagnosis was confirmed. The bipolar disorder diagnosis was included in the psychiatry follow up assessment dated [DATE]. He stated that he could have documented better about how he concluded Resident #44 had bipolar disorder in the 12/31/24 note when looking back in hindsight. He said the bipolar disorder diagnosis was provisional based on her response to the Risperdal, and he made a mistake in the note when he listed Continue Risperdal in the Treatment Plan section of the note. A psychiatry follow up assessment dated [DATE] completed by Psychiatric NP #3 revealed that there was not any documentation that included bipolar disorder. Under current medications Risperdal oral tablet 0.5mg once daily in the afternoon for bipolar disorder was listed. Resident #44 told Psychiatric NP #3 that she felt sad. No hallucinations were noted in the assessment. A telephone interview was conducted with Psychiatric NP #3 on 5/08/25 at 3:20 PM. She revealed that she saw Resident #44 on 2/21/25 for insomnia and depression. Resident #44 did not have any concerns with auditory hallucinations on 2/21/25. Psychiatric NP#3 stated she was unaware of the newly diagnosed bipolar disorder and did not research it. She might have reviewed the psychiatry follow up assessment from 12/31/24 because she often reviewed prior notes to understand why the antipsychotic was prescribed. The assessment automatically generated the medication list, but she was not sure where the bipolar disorder diagnosis came from. Psychiatric NP #3 indicated Psychiatric NP #2 should have discussed the new diagnosis with the Director of Nursing (DON). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatry follow up assessment dated [DATE] completed by Psychiatric NP #1 revealed that Resident #44 had a diagnosis of bipolar disorder and received an antipsychotic. Documentation included that a GDR would be clinically contraindicated for Risperdal. A telephone interview was conducted with Psychiatric NP #1 on 5/08/25 at 10:04 AM. She revealed that she began seeing residents at the facility in March 2025. The bipolar disorder diagnosis was automatically generated in the assessment for Resident #44 on 3/3/25. Psychiatric NP #1 stated that she did not know the origination of the diagnosis but rather that it was associated with the order for Risperdal on 12/31/24. Review of Resident #44's annual MDS assessment dated [DATE] revealed the resident was coded as receiving an antipsychotic without a gradual dose reduction (GDR) attempted and the physician did not document a GDR as clinically contraindicated. During a telephone interview with the Pharmacist on 5/08/25 at 1:10 PM, she revealed that she reviewed Resident #44's medical record and saw that Risperdal was ordered on 12/31/24 and associated with bipolar disorder. During her monthly medication reviews and a new antipsychotic was initiated, she would review the origination of the diagnosis. The Pharmacist stated she was required to ensure that any medication had an appropriate diagnosis. For Resident #44, she only looked at the Risperdal order dated 12/31/24, which had an appropriate diagnosis for the medication, and she did not question the bipolar disorder diagnosis. An interview was conducted with the Director of Nursing (DON) on 5/08/25 at 3:41 PM. She revealed that no provider had notified her of Resident #44's bipolar disorder diagnosis initiated on 12/31/24. Had they done so, she would have included this information in Resident #44's medical record and then notified all necessary personnel. The DON indicated that an assessment would support the order with a new diagnosis; however, an order with a new diagnosis would not support the assessment. The Administrator was interviewed on 5/08/25 at 4:13 PM. He revealed that Psychiatry NP#2 should have notified the DON as soon as bipolar disorder was decided as a new diagnosis, so that the appropriate departments could respond as instructed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observations, resident and staff interviews, and record review, the facility failed to apply a right-hand palm guard for 1 of 1 resident reviewed for a range of motion (Resident #15). The findings included: Resident #15 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, hemiplegia (complete paralysis) affecting the left nondominant side, contractures of multiple sites, and cognitive communication deficit. A physician's order for Resident #15 dated 1/26/23 revealed a green carrot (a green carrot palm guard is a therapeutic device designed to support and protect the fingers from the palm. It is typically made of smooth cotton fabric and packed with washable wool fleece, which helps keep the hand cool and dry while reducing friction and irritation.) applied to the right hand on at night and off during the day. Resident #15's quarterly Minimum Data Set assessment dated [DATE] revealed she was moderately cognitively impaired. Resident #15 had impairments on bilateral upper and lower extremities. Record review of the nursing progress notes for April and May 2025 revealed no documentation for Resident #15's refusal to have the carrot placed in her right hand. Resident #15's April 2025 Medication Administration Record (MAR) revealed no order for a green carrot to be placed in her right hand at night and removed the next morning. Resident #15's May 2025 MAR revealed no order for green carrot to be placed in her right hand at night and removed the next morning prior to 5/7/25. An interview and observation was made on 5/7/25 at 8:00 am revealed Resident #15 sitting up in her bed awake and her right hand resting on the right side of her bed without the carrot. When asked did the nursing staff place the carrot in her right-hand last night, she replied, No. Resident #15's right hand was observed, and her fingernails were neatly trimmed. There was no redness or irritation noted to her palm. In an interview with Nursing Assistant (NA) #1 on 5/7/25 at 9:29 am, she indicated Resident #15 was supposed to have a carrot in her right hand at night to protect the skin from moisture, pressure and nail puncture injuries. When asked where the carrot was, NA #1 presented the carrot from the second drawer of Resident #15's night stand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Unit Manager (UM) #1 on 5/7/25 at 11:15 am, she stated Resident #15 was supposed to have the carrot placed in her right hand at night and removed the next morning. She further stated the carrot was to be placed in Resident #15's right hand at 7:00 pm. UM #1 indicated the night shift and/or the day shift nursing staff would remove the carrot from Resident #15's right hand the next morning. When asked where the nursing staff documented the carrot being placed and being removed for Resident #15, she stated it was on the Medication Administration Record (MAR). The UM #1 looked on Resident #15's MAR and stated the order was placed in the wrong area and immediately corrected the error. In an interview with the Occupational Therapy (OT) Director on 5/7/25 at 10:31 am, she explained Resident #15 was not currently being seen by the therapy department. The OT Director further explained the nursing staff would make referrals for Resident #15 for therapy services and Resident #15 would be picked up on caseload. The therapy department would evaluate and work with Resident #15. The OT Director stated Resident #15 was to have the carrot placed in her right hand and was in the functional maintenance program. She further stated she had in serviced the nursing staff on how to place the carrot in Resident #15's right hand. A second observation made on 5/8/25 at 6:16 am revealed Resident #15 lying in bed on her back and appeared to be sleeping. The resident's right hand was resting on her waist with her fingers closed against her palm. In a telephone interview with NA #3 on 5/8/25 at 11:29 am, he stated he cared for Resident #15 on 5/7/25 during the 3:00 pm to 11:00 pm shift. When asked did he place the carrot in Resident #15's right hand, he replied day shift placed the carrot, and my shift removed the carrot. When asked did he remove the carrot from Resident #15's right hand during his shift on 5/7/25, he replied, No. After the order was recited to NA #3, he then indicated he had placed the carrot in Resident #15's right hand during his shift on 5/7/25. During an interview with NA #2 on 5/8/25 at 6:18 am, she stated she was assigned to care for Resident #15 during the night shift (from 11:00 pm on 5/7/25 until 7:00 am on 5/8/25). When asked did Resident #15 have a carrot in her right hand at the beginning of her shift, she replied, No. NA #2 further stated Resident #15 should have had the carrot in her right hand but did not know why the carrot was not in her right hand. NA #2 indicated the 3:00 pm to 11:00 pm shift placed the carrot in Resident #15's right hand and the 11:00 pm to 7:00 am shift removed the carrot from Resident #15's right hand. In an interview with Resident #15 on 5/8/25 at 6:20 am, she was asked if the carrot was placed in her right hand at 7:00 pm on 5/7/25, she replied, No. When asked if she refused to have the staff place the carrot in her right hand, she replied, No. Nurse #1 was interviewed on 5/8/25 at 6:30 am and stated did not see a carrot in Resident #15's right hand during her assessment. She further stated that she was an agency nurse and was not familiar with Resident #15. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 5/7/25 at 11:15 am, she stated she was aware of Resident #15's right hand carrot palm guard and Resident #15 would refuse at times. The DON indicated the order should have been placed on the MAR for the nursing staff to document placement and refusals. The DON further indicated the nursing staff should have attempted to place the carrot in her right hand and if Resident #15 refused, the nursing staff should have documented the refusals.

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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. 43222 Based on observation and staff interviews, the facility failed to implement a system to air dry all cleaned dishes. The facility also failed to follow the manufacturer's instructions for a minimum temperature of 120 degrees Fahrenheit (F) and the sanitization up to the required level of at least 50 parts per million (ppm) for three of three observations. These practices had the potential to affect food served to residents. The findings included: An observation and interview with the Certified Dietary Manager (CDM) were conducted on 5/05/25 at 10:43 AM in the kitchen. The CDM stated that all dishes near the dish room were ready for service. The following cleaned dishes were observed wet and nesting: Plate warmers (92) and domes (8) were observed face down stacked on top of each other, small ceramic bowls (79) were stacked on top of each other on a mobile cart, and coffee cups (68) and juice cups (72) were placed face down on meal trays and then stacked on top of each other (at least 3 levels). The CDM stated that the health department and previous state surveyors told her that clean/wet dishes needed to be stacked so that the water could drain downward, but nothing was mentioned about the air-dry process. It was observed that the meal trays and remaining domes were air dried on 2 separate racks. At 10:49 AM, it was observed that the outside gauge to the dish machine was not oscillating. The CDM stated normally they use a temperature pad to measure the wash/rinse cycles for the dish machine temperature log. An interview was conducted with Dietary Aide (DA) #1 on 5/05/25 at 10:51 AM. He stated that he was instructed by the CDM to stack all dishes after being cleaned because there was not any room for the air-dry process. An observation and interviews with DA #1 and the CDM were conducted on 5/05/25 at 10:52 AM. The temperature pad placed on a dish rack and passed through the dish machine measured 115.7 degrees F for the wash/rinse cycles. The CDM stated the minimum required temperature of the dish machine was 120 degrees F. Also, the CDM used a testing strip to measure the dish machine sanitization level, and it remained without color and did not reach the 50 ppm minimum requirement. The dish machine temperature log for 5/7/25 was recorded as 100 ppm and 115 degrees F. DA #1 stated the minimum temperature was supposed to be 120 degrees F. The CDM stated DA #1 did not notify her that the dish machine did not meet the required temperature that morning. DA #1 stated he told the Maintenance Assistant about the inadequate temperature measurement but continued to wash the dishes from breakfast anyway. The CDM instructed DA #1 to rewash all dishes from breakfast once the dish machine temperature was brought up to the minimum requirement of 120 degrees F. An observation of the tray line area was conducted on 5/05/25 at 11:00 AM. Forty-nine dinner plates in the warmer ready for service were wet and nesting, and ten cereal bowls were stacked on top of each other on a rack wet and nesting. Dietary Aide #2 was interviewed on 5/05/25 at 11:03 AM. She revealed that she was taught by the CDM to store clean dishes stacked on top of one another and not air-dried. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with the Maintenance Assistant on 5/05/25 at 11:04 AM. He stated he was not made aware that the dish machine did not meet temperature or sanitization requirements this morning. The Maintenance Assistance indicated that he checked the dish machine weekly, but he was not aware of today's concerns. An observation and interview with the CDM were conducted on 5/07/25 at 9:40 AM. The dish machine measured 50 ppm for sanitization. However, the temperature gauge was not working at the time. The CDM stated that the temperature pad device was no longer working, but the dish machine gauge measured 120 degrees F earlier that morning, which was marked on the dish machine temperature log. It was observed that the dish machine gauge reached 118 degrees F. The CDM contacted the Maintenance Assistant, and he arrived shortly after. An observation of the kitchen was conducted on 5/07/25 at 9:41 AM. The plate warmers (42) and domes (17) were stacked wet on top of each other after being sent through the dish machine. The coffee cups (25), juice cups (29), and small plastic bowls (59) were also wet face down on meal trays and then stacked on top of each other (3 levels total). During a follow-up interview with the CDM on 5/07/25 at 11:26 AM, she revealed that she tried to purchase a new temperature pad from local sources, but it was not available. So, the Maintenance Assistant used a heat gun, and the temperature measured 119 degrees F. The CDM indicated that the Administrator purchased a new temperature pad, and it was scheduled to arrive on 5/8/25. An observation of the kitchen was conducted on 5/07/25 at 11:27 AM. The domes, plate warmers, and dinner plates were air dried prior to service. However, the coffee cups (25), juice cups (29), and small plastic bowls (59) were still wet and stacked on top of each other with a meal tray in between. An interview was conducted with the Administrator on 5/07/25 at 11:28 AM. He stated that the kitchen staff needed to use plasticware because the dish machine was unable to reach the minimum required temperature during use. During a follow-up interview with the CDM on 5/07/25 at 11:30 AM, she stated that the dish machine reached 121 degrees F on 5/6/25, and she was not sure why there was an issue today. During a follow-up interview with the Maintenance Assistant on 5/07/25 at 11:35 AM, he stated that the dish machine had reached 121 degrees F consistently with the heat gun after he inspected it. During a follow up interview with the Administrator on 5/08/25 at 3:59 PM, he revealed that the cleaned dishes should have been air dried and not stacked prior to service. Although there was limited space in the kitchen, it could have been used to manage the air-drying process. The Administrator indicated there was an issue with the dish machine reaching the required minimum temperature of 120 degrees F because the heating unit underneath had kicked off to prevent an electrical fire due to a buildup of water. Once the water buildup was addressed, the heating unit was turned back on. The flow of chemicals needed to be adjusted anytime the measurement did not reach at least 50 ppm.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 43222 Based on observation and staff interviews, the facility failed to close the doors to dumpsters that contained waste. This was for 2 of 3 dumpsters observed and the deficient practice had the potential to attract pests and rodents. The findings included: An observation of the dumpster area and interview with the Certified Dietary Manager (CDM) were conducted on 5/05/25 at 11:20 AM. Both doors to the middle dumpster area and the right door to the far-left dumpster were left open. The CDM stated the dumpsters were shared by all departments and they all were educated to keep all doors to the dumpsters closed. During an interview with the Administrator on 5/08/25 at 3:59 PM, he revealed that he checked the dumpsters routinely to ensure the area was clean and all doors were closed. Therefore, the doors to the dumpsters were rarely left open. The Administrator indicated that he was not on the property the morning of 5/6/25, and a housekeeper was discarding trash and left the doors open by mistake. They should have closed all the doors after the trash was placed in the dumpsters.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observations, record review, staff and a pest control service technician interviews, the facility failed to maintain an effective pest program that was free of roaches for 3 of 4 observations for pest control. The findings included: Review of the pest control invoices provided by the Administrator from February - April 2025 revealed the following information related to cockroach activity and pest control identification of problem areas: 2/21/25: Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - spilled food material found on the floor. This has been like that for months and remained untouched. Structural concerns: kitchen area interior - floor tiles or baseboards loose/missing. Near Entry Interior - hole/gap noted exit door next to front desk. 3/25/25: Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - Spilled food material found on the floor of the kitchen. This has remained untouched for months. Structural concerns: kitchen area interior - Hole/gap noted by the cooler in the kitchen. Also, floor tiles or baseboards missing/loose in the kitchen. 3/28/25: Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - spilled food material found on the floor. This has been like that for months and remained untouched. Structural concerns: kitchen area interior - hole/gap noted by ice machine in scrapping area; Many areas in need of work and fixing; floor tiles or baseboards loose/missing. Near Entry Interior - exit door does not close/seal properly 1/4-inch gap or greater exists 4/24/25 Cockroach activity was not observed during service. Sanitation issues: kitchen area interior - spilled food material found on the floor. This has been like that for months and remained untouched. Structural concerns: kitchen area interior - hole/gap noted by ice machine in scrapping area; Many areas in need of work and fixing. Rear door introduction point -needs door sweeps Review of the facility's Pest Activity Log from March - May 2025 revealed the following sightings: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/31/25: multiple cockroaches found in room [ROOM NUMBER]A 4/29/25: large-sized cockroaches found by activity room and near room [ROOM NUMBER] 4/30/25: medium-sized cockroach found near nursing station 2 5/1/25: large-sized cockroach found in conference room An observation and interview with the Certified Dietary Manager (CDM) were conducted on 5/05/25 at 10:37 AM. A live, brown roach was seen in the CDM's office adjacent to the kitchen. The CDM explained the pest control company sprayed recently for cockroaches, and the Maintenance Assistant also sprayed for cockroaches. She indicated she had seen more German cockroaches with the warmer weather. The CDM then stepped on the cockroach and killed it. During an observation outside of room [ROOM NUMBER] on 5/05/25 at 11:56 AM, a live, brown roach was noted climbing the wall in the hallway. An observation and interviews with Wound Nurse #1 and Wound Nurse #2 on 5/07/25 at 2:44 PM. During wound care in room [ROOM NUMBER], a live, brown roach came out from under the bed and moved towards the window. As soon as it sensed motion in the room, the roach went back under the bed towards the wall next to the door and could not be observed. Wound Nurse #1 stated that she had never seen roaches previously in the facility. An interview was conducted with the Maintenance Director on 5/08/25 at 8:40 AM. He revealed he began with the facility in August 2024. The Maintenance Director indicated when the pest control service technician visited the facility bimonthly, he accompanied him during the tours. He stated there was a pest control sighting log at each nursing station, to keep track of sightings of pests, where the pests were observed, and the pest control service technician used the logs as a reference of where to tend to in the building in addition to the routine monthly service. The common areas and the kitchen were treated at each visit. As far as the pest control recommendations included in the invoice to prevent further infestation, the Maintenance Director stated he would repair whatever was needed immediately if it was a small project and did not interrupt meal service. Bigger projects were reserved for a scheduled time. The Maintenance Director stated he had completed a lot of work in the kitchen, including floor tiles and baseboards. However, he stated he could not provide any receipts or work orders for the work completed in the kitchen. The hole/gap by the ice machine in the scrapping area was sealed a month ago. The gap at the exit door (courtyard) next to the front desk was filled. On 4/24/25, the Many areas in need of work and fixing in kitchen could not be explained by the Maintenance Director. The pest control service technician never discussed the spilled food in the kitchen with him, and perhaps the CDM would know more. The Maintenance Director revealed the details included in the 4/24/25 pest control invoice related to hole/gap noted by ice machine in scrapping area and 'Many areas in need of work and fixing' were incorrect. He revealed he did not accompany the pest control service technician during his visit on 4/24/25 and may have been busy with something else. The Maintenance Director stated the cockroach activity had improved since he was hired in August 2024; however, he could not give an expert opinion on why cockroaches were still being observed. However, a new pest control company was contacted to hopefully further improve the situation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Rose Manor LLC	4230 North Roxboro Street Durham, NC 27704

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of the kitchen and interview with the Maintenance Director on 5/08/25 at 9:01 AM, he showed where in the kitchen he had made repairs including the hole filled next to ice machine in scrapping area and holes sealed behind the sink in cook's area as well as tiles re-caulked, and baseboards replaced. However, the baseboard replaced was not completely sealed to the wall and had a 12-inch separation gap present. He also showed that he had replaced tiles and filled in holes behind the 3-compartment sink at the baseboard area; however multiple gaps were observed between tiles connected to the wall and the flooring where the sealant was missed. During a follow up interview and observation with the CDM on 5/08/25 at 9:07 AM. The CDM stated the pest control service technician never spoke to her about areas that needed attention in the kitchen. She further stated they did not normally spray well during their visits in the kitchen, and she had to guide them to additional areas before they left the area. The CDM indicated the Maintenance Director never discussed with her the spilled food descriptions included on the February - April 2025 pest control invoices. The dry goods area was observed, and seasoning, jelly, and food crumbs were on the floor in multiple areas. The CDM stated that kitchen staff swept and mopped the entire kitchen 3-4 times daily and all those spilled areas were new on 5/8/25. Dietary Aide #1 was interviewed on 5/08/25 at 9:11 AM. He revealed he saw cockroaches in the kitchen multiple times in the past with the most recent sighting today (5/8/25) when the silverware/condiment holders were replaced on the tray line. He stated that the CDM was present in the kitchen at that time and saw the roaches near the tray line. An interview was conducted with [NAME] #1 on 5/08/25 at 9:12 AM. She revealed she last saw cockroaches in the morning (5/8/25) on the steamer when it was turned on and the area where the silverware/condiment holders were replaced on the tray line. [NAME] #1 stated the CDM was also present when she saw the roaches near the tray line. During an interview with the pest control service technician on 5/08/25 at 9:41 AM, he revealed he serviced the facility for pest control monthly unless the facility called for other services in between. The pest control service technician stated none of the facility staff accompanied him during his monthly tours, and the issues he identified for the past few months had not changed. He stated he also took pictures of the repeat problem areas that were not addressed. The pest control service technician indicated he had spoken to the Administrator as well the Maintenance Assistant about these issues, and they told him that they would notify the kitchen staff to clean and work on the other areas such as the baseboards (brick or ceramic) in multiple areas. The spilled food was located under the coffee machine and power to the outlet near the coffee machine was needed so that the insect light could work properly. He stated he had changed the bulbs to the insect light but did not resolve the power source problem, so he notified the Maintenance Assistant. There were pest control logs at each nursing station, and he reviewed them every time he visited the facility. He explained the pest control logs did have pest activity recorded, and he addressed each area identified. An interview was conducted on 5/08/25 at 9:18 AM with Housekeeping Staff #2. She stated she had seen cockroaches in the hallways occasionally. She further stated she killed them and did not tell anyone when she saw them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Rose Manor LLC	4230 North Roxboro Street Durham, NC 27704

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview with the CDM on 5/08/25 at 9:29 AM, she confirmed that she did see 2-3 German cockroaches near the tray line when the silverware/condiment containers were replaced on 5/08/25. She stated the Maintenance Assistant walked in shortly after and was notified about the sightings in the kitchen that morning. An interview was conducted on 5/08/25 at 9:34 AM with Nurse Aide #4. She stated she saw cockroaches in the hallways occasionally, and she called maintenance immediately. An interview was conducted on 5/08/25 at 9:44 AM with Nurse #2. She stated she saw cockroaches in the hallways on occasion. She further stated she entered each sighting in the pest control logbook. The Maintenance Assistant was interviewed on 5/08/25 at 10:44 AM. When the pest control service technician visited the facility, the Maintenance Assistant revealed he tried to be present so he could be shown what needed to be addressed. The Maintenance Assistance stated he took pictures of the identified areas and would repair whatever was needed. When sightings of any pest were recorded in the pest control log, he would contact the pest control company to come out that day. The spilled food issue was discussed when the pest control service technician during the last visit on 4/24/25; however, every time there was a meal prepared, there was spilled food, but the kitchen staff cleaned after each meal. The Maintenance Assistant indicated he had recommended another pest control company to the Maintenance Director because he had experience with the current pest control company from a previous position and did not favor the chemicals used during service visits. Since he started 8 months ago, the Maintenance Assistant stated that the pest activity had improved. Wherever there were cracks in the walls located all over the facility, they would be filled because that was a common area where pests entered and exited. The more the facility was sprayed, the more pest activity because they would find new hiding spots. The Maintenance Assistant indicated he was not aware of the cockroach sightings in the kitchen this morning (5/8/25). An interview was conducted with the Administrator on 5/08/25 at 4:06 PM. He revealed he had given specific instructions for the pest control service technician to visit with maintenance upon entry and then speak with the Administrator when leaving the facility. The Administrator stated the pest control service technician would just leave the invoices on his desk and leave without talking with the Administrator during many of his visits. The Maintenance Director also treated the rooms in between service visits. The Administrator stated he did not contact a new pest control company within the last 12 months because there was more pest activity in the building due to the changing of seasons. The expectation was that no pests were present in the building and if present, they would be exterminated immediately.