STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Wilmington	820 Wellington Avenue Wilmington, NC 28401

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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 - Minimal harm or potential for actual 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** 32968 Based on observations, resident and staff interviews the facility 1a) failed to repair torn floor linoleum in resident rooms (513 and 515), 1b) failed to remove the black greenish substance from the commode base caulking in resident rooms (511, 513, 515, 606, and 608), 1c) failed to repair a broken free standing clothes cabinet doors in resident rooms (510, 513, and 608), 1d) failed to repair leaking commode bases in resident rooms (506, 511, 513, 515, 608, 612, and 615), 1e) failed to replace broken or missing bathroom door threshold strip in resident rooms (500, 510, 612, 613, and 615), 1f) failed to replace broken or missing toilet paper dispensers in resident rooms (612), 1g) failed to repair resident's overhead lights that were either non-functioning, missing a light cover, or had broken light covers in rooms (515 and 601), 1h) failed to replace broken window blinds in resident rooms (515, 606, and 608); and 2a) failed to eliminate a strong urine and feces odor noted on the 500 and strong urine odor on the 600 hall which was also detected in residents' rooms. These failures occurred on 2 of 6 hallways (500 Hall and 600 Hall) observed for a safe, clean, homelike environment. Findings included: 1a. An initial observation on 04/30/24 at 8:30 AM revealed torn floor linoleum in resident rooms (513 and 515). 1b. An observation on 04/30/24 at 8:30 AM revealed resident commodes (511, 513, 515, 606, and 608), were noted to have black greenish substance located around the base of the commodes. 1c. An observation on 04/30/24 at 8:30 AM revealed broken free standing clothes cabinet door broken (510, 513, and 608). 1d. An observation on 04/30/24 at 8:30 AM revealed resident room commodes were leaking at their bases with strong sewage smell emanating from the leaking toilets in rooms (506, 511, 513, 515, 608, 612, and 615). 1e. An observation on 04/30/24 at 8:30 AM revealed resident rooms with broken or missing bathroom door threshold strip (500, 510, 612, 613, and 615). 1f. An observation on 04/30/24 at 8:30 AM revealed broken or missing toilet paper dispensers in resident rooms (612). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1g. An observation on 04/30/24 at 8:15 AM revealed overhead lights that were either non-functioning, missing a light cover, or had broken covers in rooms (515 and 601). 1h. An observation on 04/30/24 at 8:30 AM revealed broken window blinds in resident rooms (515, 606, and 608). An interview and observation was conducted on 04/30/24 at 3:45 PM with the Maintenance Director (MD). The MD stated there were multiple areas on the 500 and 600 halls that still needed to be addressed, repaired, or replaced. He stated he had an assistant but was slowly keeping up with facility repairs. He said he did not know what the black greenish substance was around some of the commodes on the 500 and 600 halls and did not know about the leaking commodes. He said maintenance was responsible for repairing or replacing items in the facility, and that the stained or torn bathroom linoleum needed to be repaired, along with the other items that were pointed out to him during the 500 and 600 hall tour. A follow-up facility tour was conducted on 05/01/24 at 10:20 AM of the 500 and 600 halls with the Administrator. The tour revealed: Black greenish substance around the base of resident commodes, leaking commodes, torn linoleum, missing or broken threshold strips, broken above bed lights, broken toilet paper dispenser, broken resident clothing cabinets, and broken blinds. She stated the areas observed on the 500 and 600 halls needed to be addressed and fixed. 2a. An observation on 04/30/24 at 8:35 revealed a strong smell of urine and feces which was detected in a resident's room (room [ROOM NUMBER]) and throughout the 500-hallway. This odor was also evident in Resident #50 and Resident #73's room located in the 500-hall on 04/30/24 and 05/01/24. A follow-up observation was conducted on 04/30/24 at 9:45 AM on the 500 and 600 hallways and room [ROOM NUMBER] and was noted to smell strongly of urine and feces. An interview was conducted on 04/30/24 at 8:40 AM with Resident #50. Resident #50's Minimum Data Set, dated dated dated [DATE] revealed the resident had no cognitive impairments. She stated there was always a strong odor of urine and feces in their room and the 500-hall. She said she let staff and administration know about the strong odor for at least the last 6-months, and still, it smelled awful. She said she had to ask staff to keep the hallway door shut most of the time due to the strong odor. An interview was conducted with Resident #73 Resident #73's Minimum Data Set, dated dated dated [DATE] revealed the resident had no cognitive impairments. on 04/30/24 at 8:40 AM. She stated there was always a strong odor of urine and feces in the hall, which seeps into her room. She said she let staff and administration know of the strong odor for a long time and it still smelled awful. She said she kept her door shut most of the time due to the strong foul odor. A follow-up observation was conducted on 04/30/24 at 9:45 AM of the 500 and 600 halls. Strong urine and feces odor was still present in the two hallways. An interview and observation were conducted on 04/30/24 at 3:45 PM of the 500 and 600 halls with the Maintenance Director. He stated the 500 and 600 halls odor needed to be addressed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up facility tour was conducted on 05/01/24 at 10:20 AM of the 500 and 600 halls with the Administrator. The Administrator said the strong urine odor down the 500 and 600 halls were never brought to her attention by staff or residents. An interview on 05/02/24 at 11:00 AM with the Administrator revealed that she was not aware of the strong odor of urine down the 500 and 600 halls. She stated that the facility was working hard to keep the facility clean and odor free. An interview on 05/02/24 at 11:10 AM with the Director of Nursing revealed that she was aware that occasionally there was urine odors down the 500 and 600 halls, but she felt that the strong odor down the 500-hall was from a resident with an ostomy, which is a hole in the abdominal wall allows waste to leave the body and collects the waste in a bag. An interview on 05/02/24 at 12:00 PM with Nursing Assistant (NA) #11 revealed that she worked on the 500-hall frequently. She stated that the urine smell was bad on 500-hall. She stated staff would spray down the hall but felt they did not have enough housekeeping staff, or they weren't doing their job. An interview on 05/02/24 at 12:08 PM with NA #10 revealed that she worked on the 500-hall at times. She stated that the 500 and 600 halls usually had a strong urine odor, but in the last couple of days it has been better since surveyors were in the facility. An interview on 05/02/24 at 12:10 PM with NA #9 revealed that she worked on the 500 and 600-halls. She stated the two halls had a strong urine odor. An interview was conducted with the Administrator on 05/02/24 at 5:15 PM. She revealed they were making progress and were improving residents' living environment to make it more home-like, and that it would take time. She said there were still areas in the facility that still needed to be addressed and they were actively putting plans in place through their Quality Assurance and Performance Improvement (QAPI) plan to address those areas she observed during the survey. She said her additional concerns included: repair and paint needed in resident rooms/bathrooms, repair or replace of commodes, and repair or replace of any other identified physical plant concerns that needed to be addressed. She said she was not sure where the strong odors down the 500 and 600 halls were coming from but did say a few of the residents' bathrooms had strong urine and feces odor which could have been caused by leaking toilets, the black greenish substance from the commode base caulking, or from the stained torn linoleum around the bases of some of the commodes observed. The Administrator stated it was her expectation for all the residents to have a safe and homelike environment that was clean and in good repair. 35173 2b. An initial tour of the facility was conducted on 04/29/24 at 10:55 AM. Prior to entering the 600 hall, which was noted to have an entry way where the 600 hall was to right of the entrance, a very strong odor of urine was detected. Once on 600 hall the odor was stronger and more pungent. There was a dirty linen bin and a trash bin noted on each end of the hall. Each bin had a closed lid, and they were not overflowing with dirty linens. A room deodorizing wall unit was noted to be in place at the top end of the 600 hall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #49 on 04/29/24 at 11:00 AM. Resident #49 was alert and oriented and resided on the lower end of the 600 hall. Resident #49 stated the urine smell was so bad at times, she had to keep her door closed. Resident #49 stated some days were worse than others and today (04/29/24) it was bad. Resident #49 stated the strong odor had been present for a couple of months. Resident #49 stated she notified the nursing staff of her concerns regarding the odor in the past but she did not think anything was done about it. An interview was conducted with Housekeeper #1 on 04/29/24 at 11:17 AM. Housekeeper #1 stated she noticed the urine odor as well, but she did not have any more room deodorizer on her cart to spray in the hall way. Housekeeper #1 was not sure if the deodorizer on the wall was working or if it needed to be refilled. She stated the Maintenance Director managed the unit. An observation of the 600 hall during the lunch meal on 04/29/24 at 1:07 PM revealed the urine odor was still strong and pungent prior to entering the 600 hall entrance and while walking through the 600 hall. The dirty linen bins and the trash bins were not on the units during this observation. An observation of the 600 hall on 04/29/24 at 4:10 PM revealed the urine odor remained strong and pungent and unchanged. An observation of the 600 hall on 04/30/24 at 1:30 PM revealed the urine odor remained strong and pungent and unchanged. There was a dirty linen bin and a trash bin noted on each end of the hall. Each bin had a closed lid, and they were not overflowing with dirty linens. An interview was conducted with the Maintenance Director on 05/01/24 at 1:55 PM. The Maintenance Director stated he did not notice the smell because he had sinus issues. He stated the wall unit deodorizers were put in place to help with the odor. At this time, he checked the unit to make sure the canister was full of deodorizer and that the unit was in working condition. The Maintenance Director stated the unit was working and had plenty of deodorizer in the canister. He stated the unit will send off a small mist every 5 minutes. While standing near the unit and while it was misting, the odor it sent out was very light and barely noticeable. The Maintenance Director stated he could not smell the deodorizer but felt that he was desensitized to it. An interview was conducted with the Administrator on 05/02/24 at 5:00 PM. The Administrator stated the facility was actively working on making improvements to the 600 hall to improve the environment and she thought that the odor had improved.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on record review and staff interviews, the facility failed to provide written notification of discharge or transfer to the resident and their Responsible Party (RP) of the reason for discharge to the hospital for 1 of 1 sampled resident (Resident #102) reviewed for hospitalization . Findings included: Resident #102 was admitted to the facility on [DATE]. The admission Minimum Data Set, dated dated dated [DATE] revealed Resident #102 was cognitively intact. Review of Resident #102's medical record revealed she was transferred to the hospital on 01/14/24. No written notice of discharge was documented to have been provided to the resident or her Responsible Party (RP). An interview was conducted on 05/01/24 at 8:30 AM with Social Worker #1. The Social Worker stated she was not aware that a written notification of discharge needed to be provided in writing to the resident and RP and was never directed to do so. An interview was conducted on 05/02/24 at 7:55 AM with the Administrator. The Administrator stated that the facility notified the RP by phone and was not aware that a written notification of discharge needed to the resident and RP.

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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 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** 45711 Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of Hospice services, respiratory care, nutrition and weight loss, unnecessary medications, and communication and sensory for 5 of 35 residents whose MDS assessments were reviewed (Residents #19, #47, #35, #17 and # 1). Findings included: 1. Resident #35 was admitted to the facility on [DATE] with diagnosis which included in part vascular dementia with behaviors and dementia with agitation. Review of Resident #35's electronic health record revealed a 1/23/24 Physician Assistant progress note which indicated a problem of debility with decline and was followed by Hospice. Review of Resident #35's electronic health record revealed a Hospice progress note dated 2/1/24. Further review of Resident #35's health record revealed a Hospice Team Care Plan Hospice program note which indicated resident was admitted to Hospice services on 10/20/23 and continued to receive Hospice services. Review of Resident #35's 2/1/24 quarterly Minimum Data Set (MDS) assessment revealed Hospice services while a resident was coded as No. An interview was conducted on 5/1/24 at 3:35 PM with the MDS Coordinator. The MDS Coordinator stated it was an error that Hospice was not coded on the 2/1/24 quarterly MDS assessment. An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS assessments would be completed accurately. 2. Resident #47 was admitted to the facility on [DATE] with medical diagnosis stroke, diabetes, and dysphagia (swallowing difficulty). The following weights were recorded in Resident #47's electronic medical record: 1/2/24 150.0 lbs. wheelchair 1/8/24 147.8 lbs. chair scale 1/10/24 142.0 lbs. wheelchair 2/2/24 190.8 lbs. wheelchair 3/6/24 190.5 lbs. chair scale 3/18/24 192.2 lbs. wheelchair scale (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/25/24 192.6 lbs. mechanical lift scale 3/27/24 152.8 lbs. wheelchair scale 4/3/24 156.0 lbs. sitting. Review of Resident #47's 4/5/24 annual Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairment and a weight of 156 pounds. Resident #47's assessment was coded as had no weight loss or gain in the past 30 days or 180 days. An interview was conducted on 5/2/24 at 3:05 PM with the MDS Coordinator. The MDS Coordinator revealed that she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual and Resident #47's 4/5/24 MDS assessment was coded in error. An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS assessments would be completed accurately. 3. Resident #19 was admitted to the facility on [DATE] with diagnosis which included obstructive sleep apnea, obesity hypoventilation syndrome, chronic obstructive pulmonary disease, asthma, and chronic congestive heart failure. Review of Resident #19's physician orders revealed an order dated 9/2/23 to place Continuous Positive Applied Pressure (CPAP) 10 centimeters water on resident every night at bedtime related to obstructive sleep apnea. Remove per schedule. Review of Resident #19's January 2024 Medication Administration Record (MAR) revealed entries for CPAP every night apply at bedtime related to obstructive sleep apnea were recorded. Review of Resident #19's 1/29/24 quarterly Minimum Data Set (MDS) indicated oxygen was received while a resident. CPAP while a resident was not coded on Resident #19's MDS. An interview was conducted on 5/2/24 at 3:05 PM with the MDS Coordinator. The MDS Coordinator revealed that Resident #19's 4/5/24 MDS assessment was coded in error, and it was a mistake that CPAP was not coded. An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed that she expected that the MDS assessments would be completed accurately. 37673 4. Resident #17 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation and behavioral disturbance. The MDS assessment dated [DATE] for Resident #17 documented antipsychotic medication was not received on a daily basis. (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 the February 2024 Medication Administration Record for Resident #17 revealed he had been administered the antipsychotic medication Risperidone 1 milligram (mg) each morning and Risperidone 2.5 mg each evening. In an interview with the MDS Coordinator on 05/01/24 at 13:46 PM she stated the assessment was coded incorrectly and should have been coded to reflect that Resident #17 had received an antipsychotic medication on a daily basis. In an interview with the DON on 05/02/24 at 4:00 PM she stated she expected the MDS assessments to be coded correctly. 35173 5. Resident #1 was admitted to the facility on [DATE]. Diagnoses included hearing loss. The Minimum Data Set annual assessment dated [DATE] revealed Resident #1 was cognitively intact and was coded as having adequate hearing. A review of Resident #1's care plan revealed a plan of care dated 4/3/23 for at risk for communication declines related to hard of hearing. During an interview with Resident #1 on 04/29/24 she stated she was very hard of hearing and to speak loudly or write down any questions. Resident #1 reported she had hearing aids, but she did not wear them because they did not work right. An interview with Social Worker #1 on 05/02/24 at 2:15 PM revealed Resident #1 has been extremely hard of hearing since admission. Social Worker #1 confirmed he coded Resident #1 inaccurately regarding her hearing and instead of adequate it should have been coded as severely impaired. An interview with the Administrator on 05/02/24 at 5:30 PM revealed she expected the MDS assessments to accurately reflect the resident's condition.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on observations, record review and staff interviews, the facility failed to use a clean washcloth and clean water to provide catheter care for 1 of 1 resident reviewed for an indwelling urinary catheter (Resident #61). Findings included: Resident #61 was admitted to the facility on [DATE] with diagnoses which included: Sacral ulcer stage-4, osteomyelitis of sacral area, urinary tract infection, and had an indwelling urinary catheter. A review of Resident #61's hospital discharge orders dated 01/02/24 included: Continue indwelling urinary catheter on discharge to assist stage-3 or 4 sacral and perineal wound healing in the incontinent patient. A review of Resident #61's most recent care plan dated 04/09/24 revealed: Resident #61 required staff assistance with activities for daily living related to history of ulcers and had an indwelling urinary catheter related to wound healing stage-4 wound. A review of Resident #61's most recent Minimum Data Set, dated dated dated [DATE] indicated resident #61 was cognitively intact and had an indwelling urinary catheter. A wound physician note dated 04/30/24 for Resident #61 revealed the patient had an indwelling urinary catheter, which both need to be cleaned and dressed daily. A bed bath and indwelling urinary catheter care observation with NA #8 was conducted on 05/01/24 at 10:20 AM. The NA #8 was observed washing Resident #61's upper arms, chest, abdomen, thighs, and groin area. Then NA #8 with the same washcloth and basin of water proceeded to wipe the penis and indwelling urinary catheter tubing. An interview was conducted with NA #8 on 05/02/24 at 10:10 AM. NA #8 revealed she was trained to use a clean washcloth and clean water when cleaning around the penis and indwelling urinary catheter tubing. NA#8 stated she should have used a clean washcloth and emptied out the basin of dirty water and replaced it with clean water and she didn't. She said she did not bring in enough supplies to complete the bath and indwelling urinary catheter care and only brought in one washcloth. She said she did not know why she did not go and get more linen supplies or why she did not change out the basin's dirty water but knew she should have. An interview was conducted with the Director of Nursing (DON) on 05/02/24 at 11:15 AM. The DON indicated that indwelling urinary catheter care was done every shift. She revealed as a part of indwelling urinary catheter care the indwelling urinary catheter tubing should be cleansed using fresh water and a clean washcloth. The DON revealed all facility residents should receive proper peri care and indwelling urinary catheter care as well as monitoring for infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 05/02/24 at 5:15 PM. The Administrator stated she expected staff to perform indwelling urinary catheter care correctly.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and staff, Registered Dietician (RD) and Physician Assistant (PA) interviews, the facility failed to 1.) obtain and record accurate weights per physician order and verify the accuracy of a resident with a significant change in weight (Resident #47), and 2.) obtain weekly weights according to the physicians order and provide nutritional supplements for a resident with weight loss (Resident #81). This occurred for 2 of 2 residents reviewed for nutrition (Resident # 47 and Resident # 81). The findings included: 1). Resident #47 was admitted to the facility on [DATE] with medical diagnosis stroke, diabetes, and dysphagia (swallowing difficulty). Review of Resident #47's electronic health record revealed a 3/10/23 physician order for Osmolite 1.5 100 cubic centimeters (cc's) per hour for 13 hours daily related to moderate protein calorie malnutrition and dysphagia. The order was discontinued on 3/10/24. The following weights were recorded in Resident #47's electronic medical record: 1/2/24 150.0 pounds (lbs.) wheelchair 1/8/24 147.8 lbs. chair scale 1/10/24 142.0 lbs. wheelchair scale 2/2/24 190.8 lbs. wheelchair scale Review of Resident #47's electronic health record revealed a 2/19/24 physician order for weekly weights. The following weights were recorded in Resident #47's electronic medical record: 2/19/24 no weight recorded. 2/26/24 no weight recorded. 3/6/24 190.5 lbs. chair scale Review of Resident #47's electronic health record revealed a 3/10/24 physician order for Osmolite 1.5 100 milliliters per hour for 12 hours daily related to moderate protein calorie malnutrition and dysphagia. The following weights were recorded in Resident #47's electronic medical record: 3/13/24 no weight recorded. (continued on next page)

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Accordius Health at Wilmington	820 Wellington Avenue Wilmington, NC 28401

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/18/24 192.2 lbs. wheelchair scale 3/25/24 192.6 lbs. mechanical lift scale 3/27/24 152.8 lbs. wheelchair scale 4/3/24 156.0 lbs. sitting. 4/7/24 136.0 lbs. wheelchair scale 4/14/24 no weight recorded. 4/21/24 no weight recorded. 4/28/24 no weight recorded. No weight was recorded during the survey. Review of Resident #47's 4/5/24 annual Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairment, weight of 156 pounds, with no weight loss or gain and received all nutrition via feeding tube. A revised 4/17/24 care plan focus indicated Resident #47 had a nutritional problem related to malnutrition with a history of weight fluctuations with dysphagia and needing all nutrition via tube feeding. An intervention indicated Resident #47 was to be weighed at the same time of the day and recorded per the physician order. Review of Resident #47's electronic health record revealed a dietary progress note dated 4/30/2024. The registered dietician (RD) progress note indicated weight and enteral review for resident was completed. Resident with significant weight loss in the past 1 month, previously with significant weight gain. The RD note indicated to monitor weight trends and adjusted the nutrition plan of care with recommendations as appropriate. An interview was conducted with Nursing Assistant (NA)# 2 on 5/1/24 at 11:55 AM. NA # 2 indicated she was frequently assigned to Resident #47. NA #2 stated the nursing assistants were responsible for obtaining and recording the weights. NA # 2 stated the nurse informed the NAs which residents needed to be weighed each day. NA #2 stated she often did not have enough time during her shift to obtain resident weights, including the weights for Resident #47 An interview was conducted with the Registered Dietitian (RD) on 5/1/24 at 3:20 PM. The RD stated she had observed inaccurate weights and had a concern regarding the accuracy of the weights. The RD stated she expected the weight would be stable for a resident that received enteral feeding for their primary nutrition. The RD stated she was not sure if the weights recorded for Resident #47 were accurate. The RD stated if a resident had a significant weight change, a reweigh should be obtained as soon as possible after the change was observed. The RD further stated if a resident had an order for weekly weights, she expected the weights to be obtained and recorded. The RD indicated accurate weights were important for evaluation of Resident #47's tube feeding and nutritional status. The RD stated the weights recorded for Resident #47 were questionable. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 5/1/24 at 4:30 PM. The DON stated the facility had recently started a performance improvement plan on weights. Review of the Quality Assurance Performance Improvement (QAPI) program provided by the DON indicated a 4/16/24 plan was initiated for weight management and accuracy of weights. The plan indicated weights would be accurate and entered timely and followed up on accordingly. Interventions and systemic changes indicated weights would be reviewed monthly by the DON prior to data entry to alert for any questionable inaccuracies for reweight, prior to entering in the electronic medical record. The plan indicated no in-service training was implemented with staff. Monthly Quality Assurance Performance Improvement (QAPI) will review compliance with weight plan and make recommendations. QAPI will review for 3 months or longer as needed. An interview was conducted on 5/2/24 at 10:30 AM with the Unit Manager. The Unit Manager revealed there had been issues with the weights. The Unit Manager stated the nurse informed the NA each day which residents required weights to be obtained. The Unit Manager indicated the Director of Nursing was responsible for reviewing the weights. An interview was conducted with the Physician Assistant (PA) on 5/2/24 at 12:05 PM. The PA revealed she was not aware that weekly weights were not obtained on Resident #47 and was not aware of the weight change for the resident. The PA stated she expected that weights would be obtained according to the order, and she expected a resident receiving tube feeding would not exhibit weight changes. The PA further indicated she expected a reweigh would be obtained when a change in weight was observed. A follow-up interview was conducted with the Director of Nursing on 5/2/24 at 3:30 PM. The DON indicated she expected that weights would be obtained per physician orders and would be accurate. The DON stated there was a systems process failure that caused the problems with weights not being obtained as ordered or not accurate. 40044 2.) Resident #81 was admitted to the facility on [DATE] with diagnoses including dementia, chronic kidney disease, heart disease, and dehydration. A care plan dated 04/27/23 for Resident #81 revealed the potential for alteration in hydration and nutrition related to requiring fortified foods, dementia, and chronic kidney disease. The goal of care was to maintain adequate nutritional status. Interventions included in part to provide and serve nutrition supplements as ordered and obtain weights per protocol. A physicians order dated 05/03/23 for Resident #81 was to obtain weekly weights every Wednesday for monitoring. Review of Resident #81's weights recorded in the electronic medical record revealed the following: 05/01/2024 120.0 Lbs. 04/07/2024 122.8 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/13/2024 128 .1 Lbs. 03/01/2024 125.2 Lbs. 02/28/2024 126.4 Lbs 02/15/2024 130.8 Lbs 02/01/2024 131.4 Lbs 01/31/2024 130.6 Lbs 01/18/2024 131.8 Lbs 12/27/2023 140.7 Lbs 12/20/2023 140.6 Lbs 11/29/2023 142.1 Lbs 11/22/2023 142.0 Lbs 11/15/2023 141.5 Lbs 11/08/2023 137.6 Lbs 10/25/2023 141.4 Lbs 10/18/2023 141.5 Lbs 10/11/2023 141.6 Lbs 10/04/2023 176.0 Lbs 09/20/2023 176.0 Lbs 08/30/2023 173.6 Lbs 08/23/2023 173.6 Lbs 08/09/2023 172.4 Lbs. 08/02/2023 174.1 Lbs 07/26/2023 169.4 Lbs 07/19/2023 169.2 Lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/12/2023 169.1 Lbs 07/01/2023 169.2 Lbs 06/28/2023 168.1 Lbs 06/21/2023 168.0 Lbs 06/14/2023 168.1 Lbs 06/07/2023 168.0 Lbs 06/02/2023 168.8 Lbs. 05/31/2023 167.4 Lbs 05/24/2023 166.2 Lbs 05/10/2023 170.3 Lbs 05/03/2023 170.3 Lbs. A physicians order dated 02/23/24 for Resident #81 revealed Fortified diet and Nutritional Supplement three times a day for supplement to be provided on the meal tray. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #81 had severely impaired cognition. She required staff assistance with activities of daily living. She had weight loss and received a therapeutic diet. She had no rejection of care. During an observation on 04/29/24 at 1:00 PM Resident #81 was observed lying in bed. She could not answer detailed questions regarding her nutrition. Her family member was at the bedside and stated she usually visited daily for lunch. She reported her appetite was poor. There was no nutritional supplement provided on the meal tray. During an observation on 04/30/24 at 9:15 AM Resident #81 was observed lying in bed. There was no nutritional supplement on her breakfast tray. Her breakfast meal included eggs, sausage, and milk. During an observation on 04/30/24 at 01:59 PM Resident #81 was observed lying in bed. Her family member was at the bedside and stated she visited daily during lunch, and she had not been receiving supplements lately. She stated with her poor appetite she thought the supplements would benefit her. During an interview on 05/01/24 at 03:29 PM the Dietary Manager stated she did not have the order for the nutritional supplement in her order system for Resident #81 and that was why it did not populate on the meal slip. She indicated she did not know why it was missed and was not in her system. She stated she would correct the order immediately and ensure Resident #81 was provided the nutritional supplement three times a day on her meal tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 05/02/24 at 10:15 AM the Registered Dietician indicated she last reviewed Resident #81 on 04/09/24 and she had weight loss. She reported Resident #81 received a fortified diet, appetite stimulants, and nutritional supplements. She indicated there had been issues with weight consistencies and they had discussed this in the Interdisciplinary Team (IDT) meetings. She reported she was not aware Resident #81 was not receiving the nutritional supplement according to the order that was dated February 2024. She stated they recently did audits of the nutritional supplements 2 or 3 weeks ago and thought they had captured any inconsistencies and didn't know how this was missed. She stated the Dietary Manager spoke with her yesterday about this order and it was corrected. She reported she didn't know what the miscommunication was regarding not obtaining weekly weights for Resident #81. She stated weekly weights were needed to assess for weight loss and the nutritional supplement should be provided according to the order. During an interview on 05/02/24 at 12:05 PM Nurse Aide #8 stated the nurse would write on the assignment sheet which residents needed to be weighed each day. She stated Resident #81 was weighed in a weight chair or with the mechanical lift. She stated she usually gets her to stand up with 2-person assistance to obtain her weight. Once she gets the weight she reports it to the nurse. She stated she relied on the nurses to notify the nurse aides of who needed weights each day. She stated Resident #81 did get a nutritional supplement sometimes but not consistently and stated the nutritional supplements were provided by the Kitchen staff. She stated she looked at the meal slips most of the time to make sure the diet was accurate, and everything was on the tray. She indicated she didn't realize Resident #81 was supposed to get a nutritional supplement with each meal. During an interview on 05/02/24 at 11:00 AM the Physician Assistant stated she evaluated Resident #81 today and she was not aware weekly weights weren't getting done. She indicated Resident #81 was at risk for nutritional decline and had weight loss and expected weights to get done according to the order. She stated she was not aware she was not receiving the nutritional supplement with each meal and expected she received the nutritional supplement three times a day. During an interview on 05/02/24 at 12:32 PM the Unit Manager stated there had been issues with obtaining weights. She stated the nurse was supposed to let the nurse aides know each day who needed weights. She reported they tried to get the weights on the residents' shower days. They had discussed getting a weekly weight schedule posted behind the nurses station so that staff could see who needed weights done. She indicated more work was needed to improve the process for obtaining weights. She stated the nutritional supplements were provided by the Kitchen staff and should have been provided on Resident #81's meal tray. During an interview with the Director of Nursing (DON) on 05/02/24 at 10:45 AM she stated they had identified an issue with obtaining weights and accuracy of weights. She stated they had been working on correcting the process. She stated they were now having nurse aides obtain weekly weights on shower days so that if the resident refused, they could get the weight on the next shower day that week due to residents getting showers twice a week. She indicated more work including education was needed to correct their process. She stated weights should be obtained and nutritional supplements provided according to the physicians order.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, observation, and staff interviews, the facility failed to store the plastic plunger and plastic syringe used for the administration of water and medications separated resulting in the potential for bacterial growth for 1 of 2 residents (Resident #47) reviewed for feeding tube. Findings included: Resident #47 was admitted to the facility on [DATE] with medical diagnosis which included stroke and dysphagia (swallowing difficulty). Review of Resident #47's 4/5/24 annual Minimum Data Set assessment revealed the resident had severe cognitive impairment. The resident was coded as having had a feeding tube and received 51% or more of her total calories through a feeding tube. In addition, the resident was coded as received 501 cubic centimeters (cc) or more of fluid intake through a feeding tube. An observation was conducted of Resident #47's feeding equipment on 4/29/24 at 2:48 PM. The observation revealed a syringe stored with the plunger inside the syringe in a clear plastic bag hanging on an intravenous pole. The syringe had visible liquid in the tip of the syringe. An observation was conducted of Resident #47's feeding equipment on 5/1/24 at 11:55 AM. The observation revealed a syringe stored with the plastic plunger inside the syringe in a clear plastic bag hanging on an intravenous pole. The syringe had visible liquid in the tip of the syringe. An observation was conducted of Resident #47's feeding equipment on 5/2/24 at 10:05 AM. The observation revealed a syringe stored with the plastic plunger inside the syringe in a clear plastic bag hanging on an intravenous pole. The syringe had visible liquid in the tip of the syringe. An interview was conducted on 5/2/24 at 10:10 AM with Nurse # 2. Nurse # 2 revealed she was assigned to Resident #47. The nurse stated she flushed Resident #47's feeding tube and administered medications that morning. The nurse stated upon completion of the administration of the medications and the water flush she had put the plunger and syringe together and placed them back in the bag hanging on the intravenous pole. An interview was conducted on 5/2/24 at 3:30 PM with the Director of Nursing (DON). The DON revealed she expected that the plunger and syringe would be stored separately after use and they would not be stored with liquid in the syringe.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37673 Based on record review and staff interviews, the facility failed to post accurate nurse staffing information for 18 of 106 days reviewed (October 1, 2023 through April 30, 2024) and failed to complete a Daily Staffing Form on one day (12/25/23) for staffing. Findings included: A review of the nursing staff posting (report of nursing staff directly responsible for resident care) from 10/01/23 through 04/30/24 was conducted. The staff posting included the day shift 7:00 AM - 3:00 PM, the evening shift 3:00 PM - 11:00 PM and the night shift 11:00 PM - 7:00 AM. Each shift listed the category for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurses (CNAs), the census (# of residents in the facility) actual hours worked, and a column for staffing totals. A review of the actual working assignment sheets compared to the daily staff posting sheets from 10/01/23 through 04/30/24 revealed 18 of the staff posting sheets were noted to have discrepancies of actual nursing staff that were physically in the facility working at the beginning of each shift including the RNs, LPNs, and CNAs. Staff posting were not accurate on the following dates: 11/27/23, 12/08/23, 12/26/23, 12/27/23, 02/27/24, 03/02/34, 03/03/24, 03/22/24, 03/24/24, 03/26/24, 03/27/24, 03/28/24, 03/29/24, 04/02/24, 04/25/24, 04/17/24, 04/20/24 and 04/29/24. No Daily Staffing Form was completed on 12/25/23. An interview was conducted with the Scheduler on 05/02/24 at 12:25 PM. She stated that one possibility the postings were not accurate was because she filled out the posting at the beginning of the day and when staffing changed the postings were not adjusted. She also explained she left at 5:00 PM and if a change in the number of nursing staff occurred after she left or on the weekend, other staff may not have known to adjust the staff posting. She stated she had worked from home on 12/25/23, no administrative staff were on duty, and the nursing staff in the building did not complete a Daily Staffing Form. An interview was conducted on 05/02/24 at 1:30 PM with the Scheduler and the Human Resources Manager. The Human Resources Manager stated she could not explain why the excessively low weekend staffing triggered on the PBJ (Payroll Based Journal) Staffing Data Report for October 1, 2023 through December 31, 2023. She stated weekends had not been short staffed and review of the actual working schedules for October 1, 2023 through December 31, 2023 showed staffing was not short. She thought that because Agency staff did not always punch the time clock and the facility did use a lot of Agency staff on the weekends that the report may not have correctly represented the number staff who were working. In an interview with the Administrator on 05/02/24 at 4:30 PM she stated she expected the staff posting to be accurate every day. She reiterated the facility did not work short staffed on the weekends.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observations, record review, staff and Physician Assistant interviews the facility failed to discontinue an order for the antibiotic Clindamycin and an opioid medication Oxycodone. This resulted in the resident receiving 16 additional doses of the Clindamycin and 15 additional doses of the Oxycodone. This occurred for 1 of 5 residents reviewed for unnecessary medications (Resident #401). Findings included. Resident #401 was admitted to the facility on [DATE] with diagnoses that included cellulitis of the left lower limb and history of opioid dependence. The hospital discharge summary dated 04/22/24 included orders for Resident #401 for Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days. The hospital discharge summary dated 04/22/24 included orders for Oxycodone 5 mgs immediate release. Take one tablet by mouth every 4 hours as needed for pain for up to 5 days. Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days. Clindamycin was initialed as administered to Resident #401 on the following dates and times which resulted in Resident #401 receiving 16 additional doses. The order should have been discontinued after 12 doses. 04/22/24 at 11:00 PM 04/23/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/24/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/25/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/26/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/27/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/28/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/29/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/30/24 at 7:00 AM, 3:00 PM, and 11:00 PM Review of the Medication Administration Record (MAR) dated May 2024 revealed Clindamycin was administered to Resident #401 on the following dates and times: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/01/24 at 7:00 AM, 3:00 PM, and 11:00 PM 05/02/24 at 7:00 AM Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Oxycodone 5 mgs give 1 tablet by mouth every 4 hours as needed for pain for 4 days. Oxycodone 5 mgs as needed was initialed as administered to Resident #401 on the following dates and times. The order should have been discontinued on 04/26/24. 04/22/24 at 10:43 PM 04/23/24 at 05:21 AM and 01:30 PM. 04/24/24 at 06:24 AM and 08:20 PM. 04/25/24 at 04:14 AM, 09:28 AM, and 03:46 PM. 04/26/24 at 06:22 AM, 01:22 PM, and 08:52 PM. 04/27/24 at 06:33 AM, 01:14 PM and 09:22 PM. 04/28/24 at 08:01AM and 03:34 PM. 04/29/24 at 12:15 AM, 09:36 AM, and 05:14 PM 04/30/24 at 05:50 AM, 10:21 AM, 02:34 AM, and 06:33 PM. Review of the Medication Administration Record (MAR) dated May 2024 revealed Oxycodone 5 mgs was administered to Resident #401 on the following dates and times: 05/01/24 at 04:39 AM, 10:52 AM, and 2:25 AM. 05/02/24 at 07:00 AM. During an interview on 05/02/24 at 2:00 PM Nurse #3 acknowledged that she was the nurse that entered the orders from the hospital discharge summary for Resident #401 and indicated she should have entered a date for the Clindamycin to be discontinued after 4 days and entered a date for the Oxycodone to be discontinued after 5 days. Nurse #3 indicated that if she did not enter dates for discontinuing the medications for Resident #401's Clindamycin or Oxycodone that it was done in error. During an interview on 05/02/24 at 10:30 AM the Physician Assistant stated the order for Resident #401's Clindamycin and Oxycodone should have been discontinued according to the hospital discharge summary. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/02/24 at 4:43 PM the Director of Nursing (DON) stated she was not aware the orders for Resident #401 were not discontinued according to the physicians order. She stated she expected the nursing staff to follow the hospital discharge summary and enter orders correctly. She indicated the nurses or unit managers entered medications into the electronic medical record. She stated the physician would be notified and education would be provided on medication administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40044 Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5%. There were 3 medication errors observed out of 25 opportunities which resulted in a medication error rate of 12%. This occurred for 2 of 3 residents reviewed during a medication pass observation. (Resident #401, #84). Findings included. a.).During a medication pass observation on 05/01/24 at 10:00 AM with Medication Aide #1 revealed Resident #401 was administered Oxycodone 5 milligrams (mg) for pain. Resident #401 was also administered Clindamycin (antibiotic) 150 mgs for infection. During the medication reconciliation on 05/01/24 of Resident #401's medications revealed a physicians order dated 04/22/24 for Oxycodone (opioid pain medication) 5 mgs give one tablet by mouth every 4 hours as needed for pain for 5 days. This order should have been discontinued on 04/27/24 but remained on the Medication Administration Record (MAR) and was administered to Resident #401 during the observation. During the medication reconciliation on 05/01/24 of Resident #401's medications revealed a physicians order dated 04/22/24 for Clindamycin 150 mgs give 3 capsules (450 mgs) by mouth every 8 hours for 4 days for cellulitis. This order should have been discontinued on 04/26/24 but remained on the Medication Administration Record (MAR) and was administered to Resident #401 during the observation. b.). During a medication pass observation on 05/01/24 at 09:15 AM with Medication Aide #1 revealed Resident #84 was administered Omeprazole 40 mgs for gastroesophageal reflux disease (GERD). His breakfast meal tray was delivered to him at the time Medication Aide #1 administered the medication and he began eating. During the medication reconciliation on 05/01/24 of Resident #84's medications revealed a physicians order dated 03/27/24 for Omeprazole 40 mgs give one capsule by mouth daily at least 30 minutes before breakfast. Review of Resident #84's Medication Administration Record (MAR) dated May 2024 revealed Omeprazole 40 mgs was scheduled for administration at 7:00 AM. During a phone interview on 05/02/24 at 2:00 PM Medication Aide #1 stated she did not know the orders for Resident #401's Clindamycin and Oxycodone should have been discontinued and not administered on 05/01/24. She indicated the medications populated on the MAR to be administered and she gave them. She stated Resident #84's Omeprazole was administered late because she had other medications to administer during that time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 05/02/24 at 2:30 PM she stated she was not aware the medications for Resident #401 should have been discontinued but remained on the MAR. She stated the physician would be notified and the medications would be discontinued. She stated Omeprazole should have been administered to Resident #84 at least 30 minutes before his meals. She stated they would review the administration time and adjust it. She stated medication orders should be followed and education would be provided to nursing staff on medication administration.

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	345236	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Wilmington	820 Wellington Avenue Wilmington, NC 28401

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35173 Based on record review, staff, Pharmacy Consultant, and the Physician Assistant interviews the facility failed to: 1a) administer an as needed antihypertensive medication as prescribed by the physician for blood pressure greater than 160 millimeters of mercury (mm Hg) resulting in 2 missed doses (Resident #3), and 1b) failed to check a blood pressure prior to administering an antihypertensive medication with parameters to hold the medication if systolic (the top number of a blood pressure reading that measures the pressure in the arteries when the heart beats) blood pressure was less than 100 (Resident #3), and 2) failed to check a resident's blood pressure prior to administering a scheduled nitrate medication used to treat angina (chest pain) with parameters to hold the medication if systolic blood pressure was less than 100 (Resident #10), and 3.) administer the full course of the oral antibiotic Ciprofloxacin prescribed for treatment of a urinary tract infection according to the Physicians order (Resident #91), and 4.) discontinue an order for the antibiotic Clindamycin and an opioid medication Oxycodone. This resulted in the resident receiving 16 additional doses of Clindamycin and 15 additional doses of Oxycodone. This occurred for 4 of 5 residents reviewed for medication administration. Findings included: 1a. Resident #3 was admitted to the facility on [DATE]. Diagnoses included, in part, stroke with left side weakness and high blood pressure. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #3 was cognitively intact. A review of the physician orders for Resident #3 revealed an order written on 01//18/23 for Clonidine HCl (high blood pressure medication) oral tablet 0.1 milligrams give one tablet every 6 hours as needed for hypertension if systolic blood pressure greater than 160 mm/hg. A review of the blood pressure recordings for Resident #3 for February 2024 revealed on 02/15/24, Resident #1's blood pressure was recorded at 5:27 AM on 02/15/24 by Nurse #7 as 189 /93 mm/hg and on 2/15/24 at 10:25 AM as 172 / 88 mmHg by Nurse #1. A review of the February Medication Administration Record revealed the Clonidine 0.1 milligram was not administered as ordered on 02/15/24 by Nurse #7 or Nurse #1. Nurse #7 no longer worked at the facility and was unavailable for interview. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #1 was interviewed on 05/02/24 at 9:37 AM and she reported when a medication was administered it was signed off in the medication administration record and a check mark would appear with the nursing initials. She stated if there was no checkmark or initials then it was not given. She stated in regard to the Clonidine 0.1 mg on 02/15/24, she said she may have given the medication to Resident #3 but could not say with 100% certainty because she did not sign it off. She stated it was important to sign off any medication that was administered so nursing staff would know that a medication was given and could monitor for effectiveness. Nurse #1 reviewed the blood pressure recordings and confirmed that the blood pressure was high at 5:27 AM with a reading of 189/93 mm/hg and it was not signed off as given by Nurse #7. She stated she could not recall if Nurse #7 passed on in report that as needed Clonidine was given due to systolic blood pressure greater than 160 mm at 5:27 AM. An interview with the Physician Assistant on 05/02/24 at 11:10 AM revealed the resident's blood pressure was elevated at 5:27 AM and remained elevated at 10:25 AM. She would have expected the medication to be given at 5:27 AM and if it had, it may not have remained elevated at 10:25 AM. The Physician Assistant stated the medication should have been administered when the nurse noted the blood pressure was 172/88mm/hg. An interview with the Director of Nursing on 05/02/24 at 4:48 PM revealed she would have expected the nursing staff to administer the ordered as needed Clonidine to help with lowering Resident #1's blood pressure. She stated the necessity of blood pressure medication was to lower the blood pressure and the nurses should have administered the medication on 02/15/24. The DON added that documenting whether or a not a medication was given was important because it was your verification that the medication was given. 1b. A review of the physician orders for Resident #3 revealed an order written on 03/01/24 for Enalapril Maleate tablet 20 milligrams give one tablet in the morning for hypertension; hold for systolic blood pressure less than 100, and an order written on 03/22/23 Amlodipine Besylate tablet 5 milligrams give one tablet every 12 hours for hypertension; hold for systolic blood pressure less than 100. A review of the Medication Administration Record for May 2024 revealed on 05/01/24 Nurse #1 administered the ordered Enalapril 20 milligrams and Amlodipine 5 milligrams at 9:00 AM as evidenced by her nursing initials and a check mark. An interview with Nurse #1 on 05/01/24 at 10:50 AM revealed she did not obtain a blood pressure prior to administering Resident #1's blood pressure medications. Nurse #1 reviewed the current physician orders in the medication administration record and confirmed the order for the blood pressure medications had parameters to hold if the systolic blood pressure was less 100 mm/hg. Nurse #1 stated she did not check the blood pressure before she administered the two medications and she should have per the order. She stated it was important to check the blood pressure before administering blood pressure medications because if her blood pressure was too low and she received the medications it could be dangerous. Nurse #1 reported according to the medical record the last time the blood pressure was taken for Resident #1 was at 3:00 AM on 05/01/24 and it was recorded as 120/63mm/hg. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Physician Assistant on 05/02/24 at 11:10 AM revealed she would have expected the nursing staff to follow the orders and obtain a blood pressure prior to administering the blood pressure medications. She added, the parameters were in the order for a reason and if the systolic blood pressure was less than 100 the medication should have been held. She stated without obtaining the blood pressure prior to administration a resident was at risk for lowering the blood pressure unnecessarily. An interview with the Director of Nursing on 05/02/43 at 4:48 PM revealed she would expect the nursing staff to follow the physician orders and obtain a blood pressure before administering blood pressure medications if the order indicated parameters to hold the medication. She added, the blood pressures medications were given to manage blood pressures and it was important to know what their blood pressure was before administering. The necessity of the drug was to lower the blood pressure and if a nurse gives a blood pressure medication when your blood pressure was already too low it could affect the resident with a negative outcome. 45711 2). Resident #10 was admitted on [DATE] with diagnosis which included in part: heart disease and hypertension. Review of Resident #10's care plan revealed a focus last revised on 4/18/24 indicated a focus of altered cardiovascular status related to angina (chest pain) and coronary artery disease. Interventions indicated in part administer medications as order and monitor for side effects and effectiveness. Review of Resident #10's 3/13/24 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact. Review of Resident #10's physician orders revealed a 4/8/24 order for Isosorbide Dinitrate Oral Tablet 5 milligrams. Give 1 tablet by mouth two times a day for angina. Hold for systolic blood pressure less than100. Review of Resident #10's April 2024 Medication Administration Record (MAR) revealed the following entry: Isosorbide Dinitrate Oral Tablet 5 milligrams. Give 1 tablet by mouth two times per day for Antianginal. Hold for systolic blood pressure less than100. Start date 4/08/2024. The entry did not include an entry for blood pressure monitoring. The MAR indicated the medication Isosorbide Dinitrate was administered daily at 8:30 AM and 8:30 PM. Review of Resident #10's electronic health record revealed the following blood pressures were recorded: 4/10/2024 5:31 AM 128/87 millimeters of mercury (mm/Hg) 4/12/2024 5:35 AM 132 / 82 mmHg 4/13/2024 4:24 AM 130 / 78 mmHg 4/14/2024 4:18 AM 159 / 77 mmHg (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/15/2024 4:05 AM 148 / 87 mmHg 4/16/2024 4:30 AM 145 / 80 mmHg 4/17/2024 5:34 AM 136 / 78 mmHg 4/18/2024 5:38 AM 128 / 76 mmHg 4/19/2024 6:21 AM 142 / 71 mmHg 4/20/2024 5:24 AM 136 / 76 mmHg 4/21/2024 6:06 AM 137 / 80 mmHg 4/22/2024 6:05 AM 134 / 74 mmHg 4/23/2024 4:41 AM 131 / 87 mmHg 4/24/2024 5:45 AM 136 / 83 mmHg 4/25/2024 5:34 AM 128 / 76 mmHg 4/26/2024 5:19 AM 130 / 72 mmHg 4/27/2024 6:04 AM 142 / 68 mmHg 4/28/2024 5:41 AM 138 / 77 mmHg 4/30/2024 4:00 AM 107 / 61 mmHg Review of a 4/24/24 pharmacy recommendation for nursing follow up indicated Resident #10 had an order to withhold Isosorbide Dinitrate if systolic blood pressure was less than 100. Review of the electronic MAR indicated the blood pressure was not routinely charted prior to medication administration. Recommendation was made to update the electronic MAR to include charting of the blood pressure with each dose of medication. Review of the May 2024 MAR revealed on 5/2/24 Nurse #2 administered the ordered Isosorbide Dinitrate at 9:00 AM as evidenced by her initials and a check mark. An interview on 5/2/24 at 10:10 AM with Nurse #2 revealed she administered Resident #10's 9:00 AM medications including Isosorbide Dinitrate. Nurse #2 stated she must have missed the part of the order that indicated to hold the medication if the systolic blood pressure was less than 100. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/2/24 at 10:30 AM with the Unit Manager. The Unit Manager stated when an order for a medication was entered into the computer, if there was a parameter to hold for a certain blood pressure reading, then the blood pressure monitoring should be linked to the order so that the readings are documented with the administration of the medication. The Unit Manager stated the order for Isosorbide Dinitrate for Resident #10 was entered incorrectly and did not include the required blood pressure monitoring and documentation. An interview on 5/2/24 at 11:30 AM with the Physician Assistant revealed she expected that the blood pressure would be taken prior to each administration of a medication with a parameter. If the resident received the medication twice per day, the Physician Assistant stated she expected the blood pressure to be checked and documented twice per day. The PA stated it was important to document the blood pressure readings to determine if there was a trend and she would need the complete documentation to evaluate this. She added the parameters were in the order for a reason and if the systolic blood pressure was less than 100 the medication should have been held. Interview on 5/2/24 at 3:30 PM with the Director of Nursing revealed she expected the nursing staff to follow the physician order and obtain a blood pressure prior to each administration of a medication if the order indicated a parameter to hold the medication. 40044 3.)Resident #91 was admitted to the facility on [DATE] with diagnoses including urinary tract infection. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #91 was cognitively intact. He had no rejection of care and received antibiotics. A care plan dated 04/30/24 revealed Resident #91 had a urinary tract infection and was at risk for complications. Interventions included to administer antibiotic therapy as ordered. A physicians order dated 04/22/24 for Resident #91 revealed Ciprofloxacin 250 milligrams, give 1 tablet by mouth every 12 hours for Infection for 5 Days. Review of the Medication Administration Record (MAR) dated April 2024 for Resident #91 revealed Ciprofloxacin 250 milligrams to give 1 tablet by mouth every 12 hours for infection for 5 Days. The medication was scheduled to be administered at 9:00 AM and 9:00 PM. The first dose was scheduled to be given on 04/22/24 at 9:00 PM. The MAR revealed only 7 of the 10 prescribed doses were administered. The MAR revealed the following: 04/22/24 at 9:00 PM the medication was not administered. 04/23/24 at 9:00 AM the medication was signed as administered. 04/23/24 at 9:00 PM the medication was not administered. Code 9 was entered on the MAR which indicated to see nursing notes. 04/24/24 at 9:00 AM the medication was not administered. Code 9 was entered on the MAR which indicated to see nursing notes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/24/24 at 9:00 PM the medication was signed as administered. 04/25/24 at 9:00 AM the medication was signed as administered. 04/25/24 at 9:00 PM the medication was signed as administered. 04/26/24 at 9:00 AM the medication was signed as administered. 04/26/24 at 9:00 PM the medication was signed as administered. 04/27/24 at 9:00 AM the medication was signed as administered. Review of the nursing progress notes for Resident #91 dated 04/23/24 at 9:00 PM and 04/24/24 at 9:00 AM revealed no documentation as to why Ciprofloxacin 250 mgs was not administered. During an interview on 05/01/24 at 10:00 AM the Physician indicated the full course of antibiotics should have been administered to Resident #91 according to the order. He stated there would be no significant outcome from not receiving the full 10 days of antibiotic treatment. He indicated Resident #91 had improved and had no further concerns. During an interview on 05/02/24 at 12:42 PM the unit manager stated she was not aware Resident #91 did not receive the full course of Ciprofloxacin. She indicated the missed doses were likely due to the medication not being received from Pharmacy at that time. She reported she had discussed with the Physicians to hold antibiotic orders until the medication was received from Pharmacy so that the administration dates were accurate in order for the resident to get the full course. She stated the dates should have been adjusted on the MAR when the medication was received from Pharmacy to ensure the exact doses were given. She indicated that was not done. The assigned nurses for Resident #91 on 04/22/24, 04/23/24, and 04/24/24 were not in the facility during the investigation and unavailable for interview. During an interview with the Director of Nursing on 05/02/24 at 2:30 PM she stated medication orders should be followed and administered according to the physicians orders. She indicated education would be provided to nursing staff on medication administration. 4.) Resident #401 was admitted to the facility on [DATE] with diagnoses that included cellulitis of the left lower limb and history of opioid dependence. The hospital discharge summary dated 04/22/24 included orders for Resident #401 for Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days. The hospital discharge summary dated 04/22/24 included orders for Resident #401 for Oxycodone 5 mgs immediate release. Take one tablet by mouth every 4 hours as needed for pain for up to 5 days. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #401 was cognitively intact. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Clindamycin 150 milligrams (mg) take 3 capsules (450 mg) by mouth every 8 hours for 4 days. Clindamycin was initialed as administered to Resident #401 on the following dates and times which resulted in Resident #401 receiving 16 additional doses: The order should have been discontinued after 12 doses. 04/22/24 at 11:00 PM 04/23/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/24/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/25/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/26/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/27/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/28/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/29/24 at 7:00 AM, 3:00 PM, and 11:00 PM 04/30/24 at 7:00 AM, 3:00 PM, and 11:00 PM Review of the Medication Administration Record (MAR) dated May 2024 revealed Clindamycin was administered to Resident #401 on the following dates and times: 05/01/24 at 7:00 AM, 3:00 PM, and 11:00 PM 05/02/24 at 7:00 AM Review of the Medication Administration Record (MAR) dated April 2024 for Resident #401 revealed Oxycodone 5 mgs give 1 tablet by mouth every 4 hours as needed for pain for 4 days. Oxycodone 5 mgs as needed was initialed as administered to Resident #401 on the following dates and times: This order should have been discontinued on 04/26/24. 04/22/24 at 10:43 PM 04/23/24 at 05:21 AM and 01:30 PM. 04/24/24 at 06:24 AM and 08:20 PM. 04/25/24 at 04:14 AM, 09:28 AM, and 03:46 PM. 04/26/24 at 06:22 AM, 01:22 PM, and 08:52 PM. 04/27/24 at 06:33 AM, 01:14 PM and 09:22 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/28/24 at 08:01AM and 03:34 PM. 04/29/24 at 12:15 AM, 09:36 AM, and 05:14 PM 04/30/24 at 05:50 AM, 10:21 AM, 02:34 AM, and 06:33 PM. Review of the Medication Administration Record (MAR) dated May 2024 revealed Oxycodone 5 mgs was administered to Resident #401 on the following dates and times: 05/01/24 at 04:39 AM, 10:52 AM, and 02:25 AM 05/02/24 at 07:00 AM. During an interview on 05/02/24 at 2:00 PM Nurse #3 acknowledged that she was the nurse that entered the orders from the hospital discharge summary for Resident #401 and indicated she should have entered a date for the Clindamycin to be discontinued after 4 days and entered a date for the Oxycodone to be discontinued after 4 days. Nurse #3 stated that if she did not enter dates for discontinuing the medications for Resident #401's Clindamycin or Oxycodone that it was done in error. During an interview with Resident #401 on 05/01/24 at 11:00 AM she was observed sitting in her wheelchair in her room. She indicated she had no concerns with receiving her medications. She had no complaints of nausea, vomiting or loose stools. During an interview on 05/02/24 at 10:30 AM the Physician Assistant stated Resident #401 did not experience any significant outcome from receiving this medication beyond the ordered time period. She stated receiving an antibiotic for a longer period of time could put a resident at risk of an infection such as C-Diff (clostridium difficile - a bacteria that causes infection of the colon which often occurred after using antibiotics). She stated overuse of an opioid could lead to dependence. During a phone interview on 05/02/24 at 5:00 PM the Consultant Pharmacist stated she had not completed the medication regimen review for Resident #401 at this time. She indicated there would be no significant outcome for receiving extra doses of Clindamycin. She indicated antibiotics could cause infection such as Clostridium Difficile. She stated the additional doses of Oxycodone that Resident #401 should not cause her any adverse outcome. During an interview on 05/02/24 at 4:43 PM the Director of Nursing (DON) stated she was not aware the orders for Resident #401 were not discontinued according to the physicians order. She stated she expected the nursing staff to follow the hospital discharge summary and enter orders correctly. She indicated the nurses or unit managers entered medications into the electronic medical record. She stated the physician would be notified and education would be provided on medication administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35173 Based on observations and staff interviews, the facility failed to air dry kitchenware before stacking them in storage and failed to ensure refrigerated meat items stored for use in the reach-in refrigerator for resident sandwiches were dated and sealed. These practices had the potential to affect food quality. Findings included: 1. During initial tour of the kitchen, beginning at 10:30 AM on 04/29/24, 8 of 8 wet tray pans were noted to be stacked on top of one another on a storage rack for use. At 10:30 AM on 04/29/24, the Dietary Manager (DM) stated that several times prior to the survey the dietary staff had been in-serviced on making sure all kitchenware was air dried before stacking it in storage. She reported that stacking pieces of wet kitchenware of top of one another in storage promoted the growth of bacteria which could make residents sick. 2. An observation on 04/29/24 at 10:40 AM of the kitchen's reach in refrigerator, with the DM revealed one bag of 16 ounce sliced sandwich ham, not sealed, or dated and open to air. The DM was unable to explain why food stored in the kitchen's reach-in refrigerator was not dated and open to air. During an interview with the DM on 04/29/24 at 10:40 AM she said she monitored the items in the refrigerators and freezers weekly when conducting inventory. She stated the bag of sliced ham should have been dated and sealed and not opened to air to prevent spoilage. During an interview with the Administrator on 04/29/24 at 5:00 PM, she reported it was her expectation the facility's kitchen staff follow all regulatory guidelines for food and kitchen sanitation safety.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on observations, record review and resident, Physician, Physician Assistant, and staff interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification and complaint investigation surveys of 11/19/21 and 1/20/23 and the complaint investigation surveys of 4/21/22, 11/8/22, and 11/20/23. This was for 6 recited deficiencies on the current recertification and complaint investigation survey of 5/2/24 in the areas of: safe, clean, comfortable, and homelike environment (584), resident assessments (F641), bowel/bladder incontinence, catheter care, urinary tract infections (F690), posting of accurate nurse staffing information (F732), medication error rate of 5% or more (759), and significant medication errors (760). The continued failure during two or more surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referenced to: F584: Based on observations, resident and staff interviews the facility 1a) failed to repair torn floor linoleum in resident rooms (513 and 515), 1b) failed to remove the black greenish substance from the commode base caulking in resident rooms (511, 513, 515, 606, and 608), 1c) failed to repair a broken free standing clothes cabinet doors in resident rooms (510, 513, and 608), 1d) failed to repair leaking commode bases in resident rooms (506, 511, 513, 515, 608, 612, and 615), 1e) failed to replace broken or missing bathroom door threshold strip in resident rooms (500, 510, 612, 613, and 615), 1f) failed to replace broken or missing toilet paper dispensers in resident rooms (612), 1g) failed to repair resident's overhead lights that were either non-functioning, missing a light cover, or had broken light covers in rooms (515 and 601), 1h) failed to replace broken window blinds in resident rooms (515, 606, and 608); and 2a) failed to eliminate a strong urine and feces odor noted on the 500 and strong urine odor on the 600 hall which was also detected in residents' rooms. These failures occurred on 2 of 6 hallways (500 Hall and 600 Hall) observed for a safe, clean, homelike environment. During the 4/21/22 complaint investigation survey, the facility failed to maintain a clean and sanitary environment by mold growing on the wall in room [ROOM NUMBER]. During the 11/8/22 complaint investigation survey, the facility failed to eliminate a strong urine odor noted on the 500 and 600 halls of the facility. During the 1/20/23 recertification and complaint investigation survey, the facility failed to: repair torn floor linoleum in resident rooms; remove the black greenish substance from the commode base caulking in resident rooms; ensure the ceilings were free from damaged drywall in shower rooms; repair a broken wall cabinet door in resident rooms; replace rough, worn, splintered handrails on the halls; repair leaking commode bases in resident rooms; repair drywall wall damage in resident rooms; replace broken or missing floor tile in resident rooms; and replace broken window blinds in resident rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Wilmington	820 Wellington Avenue Wilmington, NC 28401

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F641: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of respiratory, nutrition and weight loss, unnecessary medications, and communication and sensory (Residents #19. #47, #35, #17 and #1). During the 11/19/21 recertification and complaint investigation survey, the facility failed to accurately code the MDS assessments for activities of daily living and range of motion. During the 1/20/23 recertification and complaint investigation survey, the facility failed to accurately code the MDS assessments accurately in the areas of medication received and falls. F690: Based on observations, record review and staff interviews, the facility failed to use a clean washcloth and clean water to provide catheter care for 1 of 1 resident reviewed for an indwelling urinary catheter (Resident #61). During the 11/19/21 recertification and complaint investigation survey, the facility failed to: clarify and transcribe an order for a continuous indwelling urinary catheter to include the size of the catheter and orders to maintain and care for the catheter; appropriately perform catheter care and maintain the resident ' s dignity and privacy; and position the indwelling urinary catheter below the level of the bladder to prevent back flow of urine. F732: Based on record review and staff interview, the facility failed to post accurate nurse staffing information for 18 of 106 days reviewed (October 1, 2023, through April 30, 2024) and failed to complete a Daily Staffing Form on one day (December 25, 2023) for staffing. During the 1/20/23 recertification and complaint investigation survey, the facility failed to post complete and accurate staffing data and post daily staffing forms and failed to save the daily staffing forms for the regulatory time frame of 18 months. F759: Based on observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5%. There were 3 medication errors observed out of 25 opportunities which resulted in a medication error rate of 12%. This occurred for 2 of 3 residents reviewed during a medication pass observation. (Resident #401, #84). During the 1/20/23 recertification and complaint investigation survey the facility failed to maintain a medication error rate of less than 5%. F760: Based on record review, staff and the Physician Assistant interviews the facility failed to administer an as needed antihypertensive medication as prescribed by the physician for blood pressure greater than 160 millimeters of mercury (mm Hg) resulting in 2 missed doses (Resident #3) and failed to check a resident's blood pressure prior to administering a scheduled nitrate medication used to treat angina (chest pain) with parameters to hold the medication if systolic (the top number of a blood pressure reading that measures the pressure in the arteries when the heart beats) blood pressure was less than 100 (Resident #10). This occurred for 2 of 2 reviewed for medication administration. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the 11/8/22 complaint investigation survey, the facility failed to accurately administer medications when a resident was administered medications belonging to another resident which included a blood pressure medication and an antianxiety medication which required the resident to be sent to the emergency room for further evaluation. During the 1/20/23 recertification and complaint investigation survey, the facility failed to administer 14 doses of an antiseizure medication being used to treat schizoaffective disorder. During the 11/20/23 complaint investigation survey, the facility failed to prevent a significant medication error when a resident was administered the wrong medications resulting in a drug overdose. An interview was conducted on 5/2/24 at 5:15 PM with the Administrator. The Administrator indicated the leadership changes in the facility led to the QAPI programs not being effectively sustained. She further indicated education was needed and a process needed to be implemented to ensure medication errors would not occur. The Administrator stated the facility was actively working on making improvements in the facility to improve the environment.