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 _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 5/4/2021 through 5/11/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 965411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/4/21 through 5/11/21. Event ID# 965411. 9 of the 9 complaint allegations were not substantiated.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		5/21/21

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

Electronically Signed | 05/21/2021

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 _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to initiate a care plan for a pressure ulcer for one of one resident reviewed for pressure ulcers (Resident #15). Findings included: A review of the medical record revealed Resident #15 was admitted 8/23/2019 with diagnoses of Gastrointestinal hemorrhage, polyneuropathy, chronic embolism, Schizoaffective disorder, bipolar type. The Annual Minimum Data Set (MDS) dated 7/22/2020 noted the resident to be cognitively intact and needed extensive to total assistance with all daily care with the help of one to two persons. The Care Area Assessment indicated a risk for pressure ulcer, and this went to care plan. The care plan dated 9/4/2019 noted a focus of potential for pressure ulcer development related to decreased bed mobility. Interventions were in place. A review of the Skin Assessment dated 3/11/2021 noted open pressure wound on sacrum. The Quarterly MDS dated 4/30/2021 indicated the presence of a Stage III pressure ulcer.	F 657	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. •The care plan for resident #15 was revised by MDS Coordinator on 5/7/21 to indicate the presence of a wound on resident's sacrum. •Full skin assessment was completed on resident #15 by unit manager on 5/7/21 to ensure that any other observed pressure areas were noted and addressed on resident's care plan accordingly. •No other areas were observed. •MDS Coordinator was re-educated on F483.21 and its content, with emphasis on ensuring that all comprehensive care plans are reviewed and revised by members of the Interdisciplinary team (IDT) (includes, Social Worker, Director of Nursing, Activities Director, Dietary Manager, and MDS Nurse.) after each assessment, including both comprehensive and quarterly assessments. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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 _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2 On 5/7/2021 at 11:44 AM, the MDS Nurse stated she thought her assistant had developed a care plan for Resident #15. "I should not have assumed anything" the Nurse stated. The Administrator stated in an interview on 5/7/2021 that the MDS Nurse was responsible to make sure the care plans were completed.	F 657	•Skin observations were completed on current residents on 5/20/21 by treatment nurse to ensure that all current and/or new pressure ulcer were noted and addressed on resident's care plan to indicate the presence of pressure ulcer. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; •Clinical wound meeting has been implemented to occur weekly to ensure that any current or newly observed pressure area found on a resident, has a care plan that indicates the presence of the pressure ulcer. •The Interdisciplinary team (includes MDS Nurse, MDS Coordinator, Director of Nursing, Nurse managers, Treatment Nurse, Social Worker, Activities Director and Dietary manager). have been retrained and educated on F483.21 and it's content by the Regional Clinical reimbursement specialist on 5/21/21, with emphasis on ensuring that all comprehensive care plans are reviewed and revised by members of the Interdisciplinary team (IDT) (includes, Social Worker, Director of Nursing, Activities Director, Dietary Manager, and MDS Nurse.) after each assessment, including both comprehensive and quarterly assessments. New employees hired as members of the IDT will receive training during orientation. 4.Indicate how the facility plans to monitor its performance to make sure that	

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 _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3	F 657	solutions are sustained; •Care Plans of all residents with pressure ulcers will be reviewed by MDS Coordinator or designee daily X14, weekly X3 and monthly thereafter to ensure that all residents with pressure ulcers has a care plan that indicates the presence of the pressure ulcer and that it is resolved as needed. Findings will be documented on wound audit tool. •A Summary of monitoring efforts will be completed by Executive Director and presented at the facility monthly QA Meeting for review by the committee members to ensure continued compliance	