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 _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		12/17/21

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

Electronically Signed | 12/15/2021

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E 030	Continued From page 1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 2 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include the names and contact information for staff, residents' physicians, and other long term care facilities in the emergency preparedness communication plan. Findings included: A review of the facility's emergency preparedness plan in section E0030 for names and contact information for the communication plan revealed the contact information for staff, residents' physicians, and other long term care facilities was not included. An interview was conducted with the facility Administrator on 11/18/21 at 9:30 AM. The Administrator stated the Emergency Preparedness plan did not include the names and contact information for employees, residents' physicians, and other long term care facilities . He concluded the plan should have included this contact information and stated the information would be added to the plan.	E 030	The Plan of correction is not to be construed as an admission of any wrong doing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents E030 Names and Contact Information	

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E 030	Continued From page 3	E 030	1) The facilities Emergency Preparedness plan in section E0030 for names and contact information for the communication plan revealed contact information for staff, residents physicians and other Long term Care facilities was not included. 2) Information was added to the plan. 3) Administrator was educated on the need to fulfill requirements of the Emergency Preparedness Plan 4) Emergency Preparedness plan will be reviewed monthly for accuracy by NHA	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following:	E 031		12/17/21

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E 031	Continued From page 4 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include contact information for federal and state agencies including the State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman in the emergency plan. Findings included: A review of the facility's emergency preparedness plan in section E0031 for emergency officials contact information revealed the plan did not include contact information for federal and state agencies including the State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman. The plan only included contact information for the county Emergency Management System. An interview was conducted with the facility Administrator on 11/18/21 at 9:30 AM. He stated he was not aware the contact information for the State Licensing and Certification Agency and the	E 031	E031 Emergency Plan 1) The facilities Emergency preparedness plan did not include contact information for federal and state agencies including the State Licensing and Certification Agency and the Office of the State Long-Term Care Ombudsman. The plan only included contact information for the county Emergency Management system. 2) Information was added to the Emergency Preparedness Plan 3) Administrator was educated on the need to fulfill requirements of the Emergency Preparedness Plan 4) Emergency Preparedness plan will be reviewed monthly for accuracy by NHA	

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E 031	Continued From page 5 Office of the State Long-Term Care Ombudsman needed to be included in the plan. He concluded the plan should have included this contact information and stated the information would be added to the plan.	E 031		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted onsite 11/15/21 - 11/18/21 and remotely through 11/19/21. Event ID # NVUJ11. 1 of 1 complaint allegation was not subsantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to accurately code an MDS (Minimum Data Set) assessment for activities of daily living whose MDS assessment was coded as extensive assist for eating and toilet use for a dependent resident (Resident #57) and failed to accurately code an MDS assessment for range of motion (Resident #15) for 2 of 18 residents whose MDS assessment were reviewed. Findings included: 1) Resident #57 was admitted to the facility on 08/29/16 with diagnoses that included diffuse traumatic brain injury with loss of consciousness of unspecified duration, spastic hemiplegia	F 641	The Plan of correction is not to be construed as an admission of any wrong doing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination	12/17/21

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F 641	Continued From page 6 affecting right dominant side, paraplegia, pedestrian on foot injured in collision with car/pick up truck or van in non-traffic accident, intracranial injury, and dysphagia. Review of an annual MDS assessment dated 10/24/21 documented Resident #57 had severely impaired cognition. He was always incontinent of bowel and bladder. He had a feeding tube and a tracheostomy. He had an impaiment of his upper and lower extremities on both sides. The assessment documented he required extensive assistance from staff for bed mobility, eating and toilet use. He was dependent for transfers, locomotion, dressing, personal hygiene and bathing. In an interview with the facility Administrator on 11/18/21 at 9:30 AM he stated he expected the information contained in the MDS assessments to be accurate. In an interview on 11/18/21 at 12:05 PM with Nurse #8, MDS, he stated Resident #57 was not able to assist with eating or toilet use and was dependent for both ADL's. He concluded the assessment was coded inaccurately by documenting the resident had required extensive assistance. He stated a modification would be transmitted to correct the assessment that was completed on 10/24/21 to reflect Resident #57 was dependent for toilet use and feeding.	F 641	privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F641 Accuracy of Assessments 1) Resident #57 had a modification completed on 11/19/21 for ARD 10/24/21 to reflect total care for eating and toilet use. Resident #15 had a modification completed 11/18/21 for ARD 9/16/21 to include Bilateral lower extremity contractures. Both assessments have been transmitted and accepted. 2) The facility has determined that all residents have the potential to be affected by inaccurate MDS coding for Activities of Daily Living. On 12/3/21, the MDS Coordinator completed an audit of current residents for contractures and splint use and assistance level with eating and toileting for accurate coding. Modifications to the most recent MDS have been transmitted and accepted as appropriate to ensure coding accuracy. 3) An in-service education program was conducted by the Clinical Reimbursement Consultant with MDS Coordinator(s) addressing the importance of identifying accurate ADL ability and contractures with each MDS completed. The MDS coordinator will review POC ADL documentation during 7-day look back period to ensure accurate MDS coding for	

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F 641	Continued From page 7 2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers. The quarterly MDS assessment dated 09/16/21 revealed Resident #15 was severely cognitively impaired and had no impairments. An observation of Resident #15 on 11/15/21 revealed the resident was severely contracted to his bilateral lower extremities. The resident was noted to be wearing off loading boots to bilateral extremities. An interview with Nurse #1 on 11/17/21 at 10:35 AM revealed the resident has had bilateral lower extremity contractions for at least 6 months or more and could not ambulate. An interview was conducted with Nurse #8 (MDS Nurse) on 11/18/21 at 3:00 PM. Nurse #8 stated when he needed to complete an assessment he would review the physician orders, progress notes, and therapy orders, would interview the nursing staff and he would conduct a visual assessment on the resident. Nurse #8 stated he was not aware Resident #15 had bilateral contractures and he should have coded him with bilateral lower extremity impairments on his quarterly assessment. An interview with the Administrator on 11/18/21 at 4:17 PM revealed he expected the MDS nurses to update the assessment to accurately reflect the residents ' current care.	F 641	Activities of Daily Living. Newly hired MDS Coordinators will receive education during orientation. 4) The Director of Nursing Services, or designee, will conduct a random audit of three (3) residents MDS submissions per week x four (4) weeks then monthly x two (2) months. These residents and their MDS/medical records will be reviewed to ensure that ADLs and ROM ability are identified and accurately coded on MDS assessment. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with MDS coding accuracy.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		12/17/21

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F 684	Continued From page 8 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician and physician assistant (PA) interviews, the facility failed to follow the physicians' orders to obtain blood sugars and administer insulin for 1 of 1 resident reviewed for insulin administration (Resident #85). Findings included: Resident #85 was admitted to the facility on 1/29/19 with diagnoses which included Type I Diabetes Mellitus (DM) and hypertension (high blood pressure). Resident #85 was admitted to the hospital from 10/2-10/5/21 for hypoglycemia (low blood sugar). The facility readmitted Resident #85 on 10/5/21. The quarterly Minimum Data Set dated 10/7/21 indicated Resident #85 was moderately cognitively impaired. A review of Resident #85's Care Plan dated 10/7/21 revealed a plan of care for diagnosis of DM. The interventions included to administer diabetes medications as ordered, dietary consult as ordered, and fasting blood sugars as ordered by the physician.	F 684	F684 Quality of Care 1) Resident #85 continued to receive insulin until discharged from the facility on 10/8/21. 2) Residents with insulin orders were audited by the DON on 11/18/21. No additional concerns identified. 3) DON/Designee provided education to facility and agency licensed nurses on following physician orders and documentation of medication administration. The licensed nurse will administer insulin as ordered by the physician and document accordingly on the Medication Administration Record (MAR). Newly hired facility and agency licensed nurses will receive education during orientation. 4) The Director of Nursing and/or licensed nurse supervisor will complete an audit of five (5) residents with insulin orders for documentation per the MAR of administration as ordered by the physician. Monitoring will be completed at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8)	

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F 684	Continued From page 9 Resident #85's physician orders listed the following orders: " Administer Lispro insulin pen (a fast-acting insulin) per sliding scale (SS): If blood sugar (BS) 0-200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350=6 units, 351-400=8 units. subcutaneously (injection into the fat layer between the skin and muscle) before meals and at bedtime for DM. " Administer 3 units of Lispro insulin (short acting) after meals for DM. Hold if meal not eaten or blood sugar <200 start date 10/8/21 at 7pm. " Administer Toujeo insulin pen (long acting insulin) one time a day at 7:30 AM for DM. Review of Resident #85's Medication Administration Record (MAR) for October 2021 revealed her blood sugar results ranged from a low of 34 to a high of 583. Review of the MAR for 10/8/21 revealed Not Applicable (NA) was documented for the BS at 7:30 AM by Certified Medication Aide (CMA) #3. The # 9 was documented for the short-acting SS scale insulin by CMA #3 at 7:30 AM. The legend for the MAR revealed a 9 meant see notes/nurses notes. The MAR note documented by CMA #3 on 10/8/21 revealed the SS insulin was not given. Further review of Resident #85's MAR revealed the short-acting insulin pen inject 3 units SQ after meals at 7:00 PM (hold if meal not eaten or blood sugar <200) was blank. There was no blood sugar documented on the MAR for 10/8/21 at 7:00 PM. A telephone interview conducted on 11/17/21 at 10:39 AM with CMA #3 revealed her job was to check the residents' blood sugars before breakfast and report them to the nurse. She stated CMAs could not administer insulin. CMA	F 684	weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with insulin administration and quality of resident care.	

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F 684	Continued From page 10	F 684		

#3 further revealed that on the morning of 10/8/21 she was behind on her medication pass and she had asked Nurse #3 to obtain the blood sugar for Resident #85 at 7:30 AM. She stated that Nurse #3 had not obtained the blood sugar or administered the sliding scale insulin for Resident #85 on 10/8/21 at 7:30 AM. She further stated that Nurse #3 had instructed her to document NA on Resident #85's MAR.

In a telephone interview conducted with Nurse #3 on 11/17/21 at 2:58 PM she revealed it was the CMAs' responsibility to obtain the residents' blood sugars and report them to the nurse. She stated it was the nurses' responsibility to administer the residents' insulin. She further stated that if the (short-acting) SS insulin was not signed off on 10/8/21 at 7:30 AM for Resident #85 then she had not given it. She further revealed she had not obtained the blood sugar on 10/8/21 at 7:30 AM. Nurse #3 revealed she was not asked by CMA #3 to get Resident #85's blood sugar on 10/8/21. Nurse #3 revealed she had given the long-acting insulin on 10/8/21 at 7:30 AM.

A telephone interview was conducted on 11/19/21 at 9:25 AM with CMA #4. She stated she had not obtained a blood sugar for resident #85 on 10/8/21 at 7:00 PM because it was Nurse #6's responsibility to administer the insulin. CMA #4 revealed she had reported the new order for 3 units of fast-acting insulin at 7:00 PM to Nurse #6. She further revealed she was unsure if Nurse #6 had obtained a blood sugar or administered the insulin.

11/19/21 Attempted to call Nurse #6 three times.

An interview was conducted on 11/18/21 at 11:07

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F 684	Continued From page 11 AM with the Physician Assistant (PA). She revealed Resident #85 would have very high blood sugars and then they would drop very low. The PA stated the medical team would allow Resident #85's blood sugars to run a little high because her blood sugars would drop so fast. She further stated she didn't think Resident #85's blood sugars would have gone up very much from not getting the 2 missed doses of fast-acting insulin on 10/8/21. An interview was conducted with Resident #85's Physician on 11/18/21 at 12:00 PM. During the interview the Physician stated Resident #85 had been in the hospital from 10/2/-10/5/21 with the diagnosis of hypoglycemia (low blood sugar). He stated Resident #85 had been a very brittle diabetic and her blood sugars would be all over the place. He revealed that blood sugars in the 300-400 range was common for her. He further revealed that he did not think the 2 missed doses of insulin on 10/8/21 at 7:30 AM and 7:00 PM led to her demise. An interview was conducted on 11/18/21 at 12:56 PM with the Director of Nursing (DON). The DON stated she didn't know why the nurses had not obtained the blood sugars or administered the fast-acting insulin on 10/8/21 at 7:30 AM and 7:00 PM. The DON stated she expected the nurses to follow the Physicians' orders and to document correctly on the MAR.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		12/17/21

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F 690	Continued From page 12 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician assistant interviews, the facility failed to: 1) 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 and failed to	F 690	F690 Bowel/Bladder Incontinence, Catheter 1) On 11/18/21, the licensed nurse obtained clarification orders for Resident #15 catheter to include catheter size,	

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F 690	Continued From page 13 appropriately perform catheter care and maintain the resident ' s dignity and privacy for 1 of 2 residents (Resident #15), and; 2) failed to position the indwelling urinary catheter below the level of the bladder to prevent back flow of urine for 1 of 2 residents (Resident #49) reviewed for catheter care. Findings included: 1a. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers. The Minimum Data Set (MDS) dated 09/16/21 quarterly assessment revealed resident #15 was severely cognitively impaired, was always incontinent of bladder and frequently incontinent of bowel and was under hospice care. Resident #15 did not have an indwelling urinary catheter during this assessment. A review of Resident #15 ' s care plan dated 09/16/21 revealed there was no plan of care for an indwelling urinary catheter. A plan of care was in place for incontinence. An observation of Resident #15 on 11/15/21 revealed the resident had an indwelling urinary catheter draining concentrated amber colored urine. The bag was noted to be hanging below the level of the bladder on the bed rail. The bag was noted to not be covered with a privacy bag and the catheter tubing was not secured with a catheter securing device. An interview was conducted with Nurse Aide (NA) #1 on 11/16/21 at 9:10 AM. NA #4 stated she did	F 690	catheter care and catheter tubing securement to ensure resident catheter care, dignity and privacy are maintained. Resident #49 catheter bag continues to be positioned below the level of the bladder to prevent backflow of urine. 2) DON completed an audit of residents with catheters for completeness and accuracy of physician orders to include size, securement and care. No additional concerns identified. 3) DON/designee provided education to facility and agency licensed nurses on obtaining and validating catheter orders are complete and inclusive of size, tubing securement and catheter care and that care is provided and documented on the Treatment Administration Record (TAR) as ordered. The licensed nurse will ensure residents with catheters receive appropriate catheter care and that orders are complete. Newly hired facility and agency licensed nurses will receive education during orientation. 4) The Director of Nursing and/or licensed nurse supervisor will complete an audit of residents with catheters for order completeness and TAR documentation as ordered by the physician. Monitoring will be completed at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with care for residents with catheters.	

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not know why the catheter tubing was not secured to the resident ' s leg and she did not know why the dignity bag was not on the catheter. NA #1 stated the hospice staff took care of it.

A hand written physician order dated 10/07/21 was in the physical chart and indicated "place a foley catheter due to contractures and promote wound healing." The order did not indicate the size of catheter to be inserted or the amount of saline to inflate the balloon which helped the catheter stay in place within the urinary tract. The order was signed by the Physician Assistant (PA) and Nurse #1.

A review of the EMR revealed the order for the catheter was entered in the EMR but it was noted to have an end date of 10/08/21 and did not indicate the size of the catheter to be inserted or the amount of saline to fill the balloon.

A review of another physician hand written order dated 10/18/21 stated "replace foley catheter." The order did not indicate the size of the catheter or the amount of saline to fill the balloon.

The Medication and Treatment Administration Records were reviewed for the month of October and November. There were no orders in place for catheter care.

A review of the physician orders on 11/16/21 in the electronic medical record (EMR) revealed there were no current orders in place for the insertion of an indwelling urinary catheter. Additionally, there were no orders in place to care for the catheter to include checking catheter for placement, daily cleansing of the catheter, changing the catheter bag monthly, securing the

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tubing, or applying a privacy bag over the catheter bag.

An interview was conducted with Nurse #1 and Nurse #2 on 11/17/21 at 10:40 AM. The nurses reviewed Resident #15 ' s physician orders in the EMR and stated there were no orders in the EMR for an indwelling urinary catheter. Nurse #1 stated she recalled putting the order in the EMR on 10/07/21 to place the foley catheter and noted that she put an end date (which meant to discontinue) on 10/08/21. Nurse #1 stated she did not know why she would have put an end date in the EMR because the catheter was for continued use. Nurse #1 stated she did not know the size of the catheter or how much saline was in the balloon. Nurse #2 stated she could not find the actual order for 10/18/21 in the EMR to replace foley catheter but that she did find a progress note she had written on 10/19/21 that the foley catheter was changed per orders with 16 French (size of the catheter) 10cc (cubic centimeters amount of saline in the balloon). Nurse #1 and #2 confirmed, however, there were no actual orders to insert a 16 French catheter with 10cc balloon and the order only stated to replace foley catheter. Additionally, both nurses stated there should be "batch" orders which meant additional orders would have been prompted to be selected if the indwelling urinary catheter order was put in the EMR. The nurses added the batch orders included to check for foley catheter placement, cleanse the catheter daily or each shift, change the catheter bag monthly, provide dignity cover for privacy, and secure catheter tubing in place. Both nurses confirmed that without the order being put in the EMR it would not trigger to the MAR as a nursing task to ensure they were doing care for this

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catheter. The nurses stated if the order for the catheter was put into the system they would have selected the appropriate care measures and the orders would have appeared on the MAR so the nurses could check off each shift that the catheter was in place, being cleansed daily or with each shift, covered with a dignity bag, and the tubing was secured.

An interview was conducted with the PA on 11/17/21 at 2:40 PM. The PA reviewed the orders that were hand written on 10/07/21 and 10/18/21 and stated the orders should have indicated the size of the catheter to be inserted and the balloon amount. The PA stated the 16 French catheter and 10cc balloon amount was appropriate for the resident at this time, but it should have been clarified in the physician order and entered in the EMR.

1b. An observation of catheter care for Resident #15 was conducted on 11/18/21 at 2:15 PM with NA #3. NA #3 entered the resident ' s room, provided privacy, washed her hands, applied gloves, raised the resident ' s bed, lowered the bed sheets, released the brief, and proceeded to clean the catheter. NA #3 wet the wash cloth in the sink in the resident ' s room and did not apply any soap. She was noted to use only one wash cloth and proceeded to clean the catheter tubing starting at the meatus (opening of the penis) and cleansed the tubing with an up and down motion along the tubing. NA #3 did not use a separate wash cloth to clean the meatus or a separate wash cloth to clean the shaft of the penis. The tubing to the catheter was not secured to the resident ' s leg with a catheter strap.

An interview was conducted with NA #3 on

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11/18/21 2:35 PM. NA #3 reported she had been a nurse aide for 3 years but that she did not usually clean catheters. NA #3 stated she did not realize she was doing it wrong and could not recall the last time she was educated on catheter care. NA #3 stated the tubing should be secured to prevent the tubing from kinking. NA #3 stated she would let the nurse know that it was not secured.

An interview was conducted with the Director of Nursing (DON) on 11/18/21 at 4:15 PM. The DON stated there should have been an order to insert the indwelling catheter to include the catheter size and the balloon amount. The DON stated she would have expected the nurses to clarify the order when it was written by the PA. The DON stated the order should have been put into the EMR so it would have triggered the additional batch orders to the MAR so the nurses could monitor the catheter for placement, ensure it was getting cleansed each shift and the catheter bag was covered for dignity and the tubing was secured. The DON could not say for certain any of these tasks were being done daily or each shift since it never made it to the MAR for the nurses to sign off that the task was completed. The DON reported catheter care education was done upon orientation with a return demonstration and annually. The DON stated NA #3 had been educated on catheter care and she should have known how to clean a catheter appropriately.

2.) Resident #49 was admitted to the facility on 09/28/21. His diagnoses included in part; end stage renal disease, hemiplegia, diabetes, pressure ulcers, and retention of urine.

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A physician's order dated 09/28/21 revealed; indwelling urinary foley catheter to straight drainage 16 FR (French) with 10 milliliter balloon related to chronic urinary retention.

The Minimum Data Set (MDS) admission assessment dated 10/04/21 revealed Resident #49 was nonverbal. He required two-person extensive assistance with bed mobility, transfers, and activities of daily living (ADL's). He had an indwelling catheter and multiple pressure wounds which were present on admission.

The care plan dated 10/11/21 revealed Resident #49 had a plan of care in place for an indwelling suprapubic catheter related to sepsis and multiple pressure wounds. The goal of care included Resident #49 would show no signs or symptoms of urinary infection through the review date. Interventions included in part; to position the catheter bag and tubing below the level of the bladder and check tubing for kinks every shift.

An observation of Resident #49 was conducted on 11/18/21 at 2:00 PM along with the wound treatment nurse (Nurse #5). The foley catheter bag with approximately 400 milliliters of urine was observed lying in the resident's bed. The tubing was not kinked. Resident #49 was awake and nonverbal. No signs or symptoms of pain or discomfort were observed.

An interview was conducted on 11/18/21 at 2:00 PM with Nurse #5. She stated the nurse aide (#2) must have left the foley bag in the resident's bed after providing incontinence care.

An interview was conducted on 11/18/21 at 2:40 PM with Nurse Aide #2. She stated she was an

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F 690	Continued From page 19 agency nurse and was the assigned nurse aide for Resident #49. She reported she provided incontinent care to Resident #49 every 2 hours during her shift and stated she had been in and out of his room several times and must have accidently left his foley catheter bag in his bed during the last round of care which would have been around 12:00 PM. She stated she was aware the foley bag should always be kept below the level of the bladder. She stated it was an oversight. An interview was conducted on 11/18/21 at 4:13 PM with the Director of Nursing (DON) along with the Assistant Director of Nursing. The DON stated she expected foley catheter care to be completed accurately and the foley bag should always be maintained below the level of the bladder.	F 690		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		12/17/21

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F 842	Continued From page 20 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 21 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to document the administration of insulin and indwelling urinary catheter tubing securement for 2 0f 18 sampled residents reviewed for medical record accuracy (Resident #85 and #15). Findings Included: 1. Resident #85 was admitted to the facility on 1/29/19 diagnoses which included Type I Diabetes Mellitus. The quarterly Minimum Data Set (MDS) assessment dated 10/7/21 indicated Resident #85 was moderately cognitively impaired. Resident #85's physician orders listed the following order to administer 15 units of Lispro insulin pen (a fast-acting insulin) subcutaneously (SQ-injection into the fat layer between the skin and muscle) one time only for blood sugar 575 with a start date 10/7/21 at 6:30 PM. Review of Resident #85's Medication Administration Record (MAR) for October 2021 the order for 15 units of Lispro insulin on 10/7/21 at 6:30 PM was blank. An interview with Nurse #4 was conducted on 11/17/21 at 4:20 PM. Nurse #4 revealed she had administered the 15 units of Lispro insulin on 10/7/21 at 6:30 PM. Nurse #4 stated she must have forgotten to document it on the MAR.	F 842	F842 Resident Records □ Identifiable Information 1) On 11/18/21, the licensed nurse obtained clarification orders for Resident #15 catheter to include securement of catheter tubing and documentation as ordered. Resident #85 was discharged from the facility on 10/8/2021. 2) Residents with insulin orders were audited by the DON on 11/18/2021. No additional concerns identified. On 11/18/21, the DON completed an audit of residents with catheters for completeness and accurate documentation. No additional concerns identified. 3) The DON/Designee provided education to facility and agency licensed nurses on 1) obtaining and validating catheter orders are complete and inclusive of size, tubing securement and catheter care and that care is provided and documented on the Treatment Administration Record (TAR) as ordered and 2) following physician orders and documentation of medication administration. The licensed nurse will	

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F 842	Continued From page 22 An interview was conducted with the Director of Nursing (DON) on 11/18/21 at 2:03 PM. The DON stated she expected the nurses to follow the Physician's orders and to document correctly on the MAR. 2. Resident #15 was admitted to the facility on 07/02/18. Diagnoses included, in part, benign prostate hypertrophy (enlarged prostate) and unstageable pressure ulcers. The MDS dated 09/16/21 quarterly assessment revealed resident #15 was severely cognitively impaired and was always incontinent of bladder and frequently incontinent of bowel and was under hospice care. Resident #15 did not have an indwelling urinary catheter during this assessment. A review of Resident #15 ' s updated plan of care dated 11/17/21 revealed a plan of care was in place for an indwelling urinary catheter with an intervention to include check tubing each shift for kinks. An observation of Resident #15 on 11/15/21 revealed the resident had an indwelling urinary catheter draining concentrated amber colored urine. The bag was noted to be hanging below the level of the bladder on the bed rail and the catheter tubing was not secured with a catheter securing device. An interview was conducted with Nurse Aide (NA)	F 842	administer, and document insulin and catheter care as ordered by the physician. Newly hired facility and agency licensed nurses will receive education during orientation. 4) The Director of Nursing and/or licensed nurse supervisor will complete an audit of residents with 1) catheters for order completeness and TAR documentation as ordered by the physician and 2) five (5) residents with insulin orders for documentation per the MAR of administration as ordered by the physician. Monitoring will be completed at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with resident records.	

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#4 on 11/16/21 at 9:10 AM. NA #4 stated she did not know why the catheter tubing was not secured to the resident ' s leg. NA #4 stated the hospice staff took care of it.

A review of the physician orders on 11/17/21 in the electronic medical record (EMR) revealed an order to check placement of catheter strap each shift.

The Medication Administration Record (MAR) for November 18, 2021 revealed a check mark and the initials of Nurse #2 indicating she had checked the placement of the catheter strap on the 7-3 shift.

An observation of catheter care for Resident #15 was conducted on 11/18/21 at 2:15 PM with Nurse Aide (NA) #3. NA #3 entered the resident ' s room, provided privacy, washed her hands, applied gloves, raised the resident ' s bed, lowered the bed sheets, released the brief, and proceeded to clean the catheter. The tubing to the catheter was not secured to the resident ' s leg with a catheter strap.

An interview was conducted with NA #3 on 11/18/21 2:35 PM. NA #3 reported she had been a nurse aide for 3 years but that she did not usually clean catheters. NA #3 stated the tubing should be secured to prevent the tubing from kinking. NA #3 stated she was not sure why there was no strap to secure the catheter tubing and would let the nurse know that it was not secured.

An interview was conducted with Nurse #2 via phone on 11/19/21 at 12:15 PM. Nurse #2 stated she thought the Nurse Aide had secured the tubing so she signed it off as done. Nurse #2

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 _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

(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 842	Continued From page 24 stated she did not check on the placement herself to ensure the tubing was secured. Nurse #2 stated when she asked if the catheter care had been done, NA #3 said it was so she assumed it included securing the catheter. An interview was conducted with the Director of Nursing (DON) on 11/18/21 at 4:15 PM. The DON reported nursing staff should not be signing off tasks as completed unless they observed that the task was actually completed.	F 842		