STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345063	A. BUILDING: _____ B. WING _____	12/1/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC

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F 657	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 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 record review and staff interviews, the facility failed to update a resident care plan to reflect the resident's current nutritional status for 1 of 26 residents whose care plans were reviewed (Resident #2). The findings included: Resident #2 was admitted to the facility on 3/09/20. Resident #2 was hospitalized on 10/28/23 and returned to the facility on 10/31/23. A physician diet order dated 10/31/23 for a carbohydrate controlled no added salt diet (CCHO/NAS), regular texture, thin consistency, and double protein with meals. The Registered Dietitian (RD) admission assessment dated 10/31/23 revealed his diet was a CCHO/NAS regular texture. The RD recommended continuation of the previous diet order to include double protein with meals. The Minimum Data Set (MDS) admission assessment dated 11/06/23 revealed Resident #2 was cognitively intact. Resident #2 was not coded for a swallowing disorder and was not coded for a mechanically altered diet. Resident #2's care plan last reviewed and revised on 11/29/23 revealed a care plan in place for nutrition risk related to a mechanically altered diet with an intervention to provide and serve diet as ordered. During an interview on 12/01/23 at 9:04 am with MDS Nurse #2 she revealed she was responsible to ensure

The above isolated deficiencies pose no actual harm to the residents

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the accuracy of Resident #2's care plan. The MDS Nurse stated when she reviewed a care plan, she checked physician orders and would revise the care plan as needed based on the physician orders. The MDS Nurse #2 stated reviewed Resident #2's physician orders but did not recall seeing the order for the regular texture diet.

An interview was conducted on 12/01/23 at 10:42 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for the accuracy of Resident #2's care plan. The DON stated Resident #2's admission orders were reviewed during the clinical meeting and the MDS Nurse attended the meeting. The DON stated the physician order for Resident #2 was entered before the last revision date of the care plan and the care plan should reflect the current order.

An interview with the Administrator was conducted on 12/01/23 at 10:07 am who revealed the MDS Nurse #2 was responsible for the accuracy of Resident #2's care plan.

F 842

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;
(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.

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§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;
(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 the record review and staff interviews the facility failed to document complete and accurate information in the Medical Administration Record (MAR) for 1 of 26 Residents (Resident #8) whose records were reviewed.

Findings included:

Resident #8 was admitted to the facility on 8/25/21.

A review of physician orders for Resident #8 dated 4/27/23 revealed she had an order for Benadryl Capsule 25 mg (milligrams) 1 capsule by mouth every 6 hours as needed for itching.

Review of the Nursing Progress Note for 4/27/23 at 1:11PM signed off by Nurse #1 revealed Benadryl 25 mg was administered for Resident #8.

A review of the MAR for 4/27/23 revealed there was no documentation or recording of the Benadryl Capsule 25 mg being administered on the same date at 1:11 PM.

During an interview with Unit Manager #1 on 11/29/23 at 2:24 PM she revealed Nurse #1 administered the medications but failed to document on the MAR the administration of the Benadryl Capsule 25mg on 4/27/23. She further revealed Nurse #1 no longer worked at the facility.

Attempts to reach Nurse #1 revealed her last known contact phone number was no longer in service.

In an interview with the Director of Nursing (DON) on 12/1/23 at 10:00 AM she revealed it was the responsibility of the nurse administering the medications to correctly document on the MAR.

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F 842	Continued From Page 3 In an interview with the Administrator on 11/30/23 at 10:22 AM she indicated that at a minimum she expected documentation of MAR to reflect accurately when the nurses administer medications.