STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 A unannounced recertification survey and complaint investigation was conducted on 3/10/25 through 3/13/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QX2G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/10/25 through 03/13/25. Event ID #QX2G11. The following intakes were investigated: NC002211513, NC00217587, NC00217739, NC00218887, NC00219430, NC00221155, NC00223384, NC00223600, NC00225485, and NC00228165. 2 of the 17 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to protect a resident's right to be free from misappropriation of property leading to a suspected monetary loss of $3957.55. The deficient practice was for 1 of 3 residents reviewed for misappropriation of resident property (Resident #27).	F 602	1. Resident #27 was made whole financially through a combination of FDIC Insurance from the bank and a check from Harmony Park for the balance that was removed from his account. Resident #27 was provided education and support about the need to properly secure his	4/4/25

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

Electronically Signed | 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 602	Continued From page 1 The findings included: Resident #27 was admitted to the facility on 10/02/23 with diagnoses including cognitive communication deficit and cerebral infarction (stroke). Resident #27's quarterly Minimum Data Set (MDS) dated 2/1/24 indicated he had intact cognition and had no behaviors. A Brief Interview of Mental Status assessment dated 4/23/24 indicated Resident #27 scored a 09, which indicated moderate cognitive impairment. The facility 24-hour Initial Report dated 5/31/24 documented an allegation that Resident #27 realized funds were missing from his bank account. The Administrator was notified on 5/31/24. The report noted the transactions appeared to have occurred over several months. It was noted Resident #27 had given his automatic teller machine (ATM) debit card to multiple people over time to buy drinks, snacks, and pizza in the past, but saw many additional unapproved withdrawals. There was no physical or mental harm noted. No alleged perpetrator was identified and the local police were notified. The facility Investigation Report dated 6/7/24 documented Resident #27 went to the bank and had three months of statements accessed and felt certain that there were expenditures that were not his. Some of the disputed charges were questionably his as they were from the vending machines he frequents in the facility. The Report noted that during a police interview with the	F 602	debit card and was provided with a lock box, a locking drawer and a bag to attach to his wheelchair that holds the lock box if needed. Resident #27 continues to be in posession of his replacement debit card and requires reminders to keep it safely secured. 2. All other residents were offered lock boxes and/or locking drawers to enable them to secure money or other items of personal importance. A reminder of this was provided at Resident Council on 4/3/2025 by the Administrator. Families received an email notice on 4/1/25 through PointClickCare reminding them of the importance of providing a secure way for their respective resident to be able to make purchases, the proper use of the Resident Financial Management System (RFMS), and the methods of securing and obtaining money within the facility. Families and residents were reminded that staff is unable to handle cash or credit cards on behalf of residents or procure items for them using their money or cards except under specific circumstances by the Activities Director, The Social Worker, or the Business Office Manager (BOM). Staff have been provided with a reminder for which they have signed stating the same information. 3. The RFMS system cash box is available 24 hours a day, 7 days a week for cash for resident/family use. Withdrawal amounts greater than 50.00 require 24-hour notice and will be provided in a check made out to the resident or the designated payee. All residents are asked to keep their personal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 602	Continued From page 2	F 602		

resident, Resident #27 identified a staff member, Nurse Aide (NA) #3, and said he had given her his debit card to pick him up a sandwich at a local sandwich shop but could not remember the day. He said that after she got him a sandwich, he noticed his money was "going faster". The Police Department stated they would contact her. NA #3 was suspended pending the results of the investigation.

An addendum to the facility investigation dated 6/16/24 written by the Administrator noted the police had notified the facility that individuals had been identified using Resident #27's debit card without authorization and one of the individuals had been arrested. NA #3, who the resident identified to the police, did not appear to be involved as per the police investigation and was taken off of suspension.

A police report by Police Officer #1 dated 6/24/24 noted there were three charges to Resident #27's debit card at ATMs on 4/22/24, 5/04/24, and 5/10/24, totaling $1709.00. Multiple other charges were noted in the report were made to various websites not used by Resident #27. Three individuals, NA #1, NA #2, and Individual #1 were identified in the investigation as having been the alleged perpetrators. Individual #1 was charged with identity theft and two counts of obtaining property under false pretenses. NA #2 was also charged with identity theft and six counts of obtaining property under false pretenses for purchases made online. The police report did not specify any charges or actions related to NA #1.

In an interview on 3/12/25 at 9:03 AM, the Administrator said NA #1 and NA #2 were contracted NAs from a staffing agency, not facility

funds in the RFMS system and are encouraged not to be in possession of large amounts of cash or cards of any kind, unless they are keeping it secured in a lock box or locking drawer. Lock boxes remain available through the Business Office Manager. Families have received an additional reminder on 4/1/25 of the importance of using RFMS to secure funds safely and are discouraged from storing cash or cards in another way. The Administrator reminded residents in Resident Council on 4/3/25 of this recommendation and the availability of lock boxes. Beginning 3/31/25 staff have been in-serviced by the Nursing Home Administrator or Director of Nursing or Department Manager designee on the Abuse, Neglect and Misappropriation Policy through 4/3/25 with all staff receiving this in-service. The in-service includes the reminder that no employees may handle cash or credit/debit cards of a resident and specific information on how they may assist. This in-service has been added to orientation for all newly hired or contract employees.
4. The BOM and the Administrator will jointly oversee the RFMS system respecting separation of duties. The Social Worker will immediately notify the Administrator of any reports of financial or card losses without regard for the amount, so reporting requirements can be met.
The Quality Assurance Performance Improvement (QAPI) Committee will monitor ongoing for any grievances, or other reports of financial or card losses and ensure appropriate and immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 602	Continued From page 3	F 602		

employees. She said Individual #1 was related to NA #1 and NA #2. She said the total amount taken from Resident #27's bank account was $3957.55.

In an interview on 03/12/25 at 9:40 AM, Resident #27 said his debit card went missing but he could not remember any details. He said the Administrator took care of everything for him and kept him informed of the investigation. He said the money had been replaced by the bank. He said he had a lock box and his nightstand drawer locked and he had the key but he preferred to keep his wallet with him at all times to maintain control of it.

In an interview on 3/12/25 at 2:54 PM, Unit Manager #1 said she was the Unit Manager on Resident #27's unit. She said Resident #27 confided in her that more money than he spent was being taken out of his bank account. The Unit Manager said she helped Resident #27 obtain his bank statements and file fraud disputes. His bank statements showed multiple purchases that the resident denied making. Some of the websites were stores, and Resident #27 had not received any package deliveries at that time. She said on one occasion, a facility staff member took Resident #27 to run errands and had Individual #1 go with them. Resident #27 told her that Individual #1 helped him take money out of an ATM because he couldn't push the buttons and that Individual #1 punched in his personal identification number (PIN). She said Resident #27 was not distressed and he just wanted to find out what happened and get his money back.

In an interview on 3/13/25 at 8:55 AM, the Administrator said neither the facility nor the

action is taken if such a report is received. The Committee will note such reports in the QAPI minutes for three months or the duration recommended by the QAPI Committee.
5. This corrective action is fully in place as of 4/4/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 602	Continued From page 4 staffing agency had current contact information for NA #2. Attempts to reach NA#1 were unsuccessful. Attempts to reach Police Officer #1 were unsuccessful during the survey. In an interview on 3/13/25 at 5:38 PM, the Administrator said the facility believed one of the NAs took Resident #27's debit card while working at the facility. They examined timecards for March, April, and May of 2024, and both NA #1 and NA #2 worked at the facility during that time period. She said as a result of the incident, the facility changed their policy on who can assist residents purchasing items and assisting resident with their money and directed staff to speak with the Social Worker, Activities Director, or the Business Office Manager. The policy said that no other staff may handle money or payment cards for the residents at any time. She said the facility sent out messages to all of the families and in-serviced all staff on the change of policy. In an interview on 3/13/25 at 8:09 PM, the Administrator said the facility created a plan of correction but had not completed the intended audits or monitored the corrections in the Quality Assurance committee as indicated in their plan.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 609	Continued From page 5 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of misappropriation of resident property to the Department of Social Services (DSS). This deficient practice affected 1 of 3 residents reviewed for misappropriation (Residents #27). The findings included: The facility 24-hour Initial Report dated 5/31/24 completed by the Administrator documented an allegation that Resident #27 realized funds were missing from his bank account. The Administrator was notified on 5/31/24. The report noted the	F 609	1. Both the Department of Social Services and the Ombudsman were notified of Resident #27's losses on March 13, 2025, by the Administrator and the Social Worker. 2.The Administrator was educated by the Regional Director of Operations about the reporting requirements on March 12, 2025. The Administrator then educated the Social Worker about the requirements on March 13, 2025, when they jointly made the notifications regarding Resident #27. A review of grievances over the past 6 (six) months indicated no other events	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 609	Continued From page 6 transactions appeared to have occurred over several months. It was noted Resident #27 had given his automatic teller machine (ATM) debit card to multiple people over time to buy drinks, snacks, and pizza in the past, but saw many additional unapproved withdrawals. There was no physical or mental harm noted. No alleged perpetrator was identified and the local police were notified. There was no documentation on the Initial Report that indicated DSS was notified. The Facility Investigation Report dated 6/7/24 completed by the Administrator documented the police were investigating and had suspects in the case. The Facility Investigation Report did not document that DSS was notified of the allegation. An addendum to the facility investigation dated 6/16/24 written by the Administrator noted the police had notified the facility that individuals had been identified using Resident #27's debit card without authorization and one of the individuals had been arrested. In an interview on 3/12/25 at 4:35 PM, the Administrator said she did not remember notifying DSS of the allegation and investigation related to the misappropriation of Resident #27's property, but would check with the Social Worker to see if she notified them. She said she was not aware that DSS had to be notified in addition to the state agency and the local police. In an interview on 3/12/25 at 5:03 PM, the Social Worker said she was involved in the investigation related to the misappropriation of Resident #27's property and DSS was not notified of the allegation.	F 609	which required reporting. 3. The Administrator and Social Worker are responsible for meeting reporting requirements. The Regional Director of Operations educated the Administrator on the Facility Reported Incident (FRI) Checklist. This audit tool will be used when a FRI occurs to ensure all notifications have been completed. The checklist will be presented by the Administrator for review at the monthly QAPI Meeting for three months. The FRI Checklist will be reviewed by the Regional Director of Operations after completion of the 5-day summary to assure all elements are compliant. 4. The QAPI Committee will review all FRIs and validate the completion of the FRI Checklist during the monthly/quarterly QAPI Meeting for three months or the time period the QAPI Committee determines is necessary to sustain compliance ongoing. 5. This corrective action is fully compliant as of April 4, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 645	Continued From page 7	F 645		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	F 645		4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 645	Continued From page 8 for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure an updated Preadmission Screening and Resident Review (PASRR) was completed prior to admission for a resident diagnosed with psychosis and depression for 1 of 2 sampled residents reviewed for PASRR (Resident #32).	F 645	1. Resident #32 has an updated Level 2 Pre-Admission Screening and Resident Review (PASRR) as of 3/20/25. 2. An audit was conducted by the Admission Coordinator on or before 3/31/2025 to ensure that all residents have a current Level 1 or Level 2 PASRR. No deficient practice was identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 645	Continued From page 9 The findings included: The North Carolina Department of Health and Human Services (NCDHHS) PASRR determination letter dated 09/30/2017 for Resident #32 revealed a level I screen and a PASRR number that remained valid for the individual's stay and no further PASRR screening was required unless a significant change occurred with the individual's status which suggested a diagnosis of mental illness. Resident #32 was admitted to the facility on 2/07/2024 with diagnoses including psychosis not due to a substance or known physiological condition and depression. The admission Minimum Data Set (MDS) dated 2/12/24 indicated Resident #32 was cognitively intact, was not evaluated by Level II PASRR and determined to have a serious mental illness, and had diagnoses of depression and psychotic disorder. The MDS indicated she had not had any behaviors or rejection of care in the assessment period and had taken antipsychotic and antidepressant medications. In an interview on 3/13/25 at 2:57 PM, the Social Services Director said the social services office, which included herself and two assistants, were responsible for ensuring a PASRR was completed prior to admission. She said she did not realize Resident #32's PASRR had not been done since 2017. She had looked through the facility files upon surveyor request for a PASRR completed after that date, but because the hospital had not sent one, she was unable to find a more recent PASRR. She said the social services office should have made sure a Level 1	F 645	Residents residing in the facility had their diagnoses and PASRRs reviewed by the Director of Nursing by 3/31/25 to validate residents with Level 2 PASRR Diagnosis had a Level 2 PASRR screening completed. No other residents had PASRRs that needed to be submitted for additional review based on diagnosis. 3. The facility Administrator educated the Admission Coordinator and Social Worker on ensuring that all residents admitted to the facility must have a Level 1 or Level 2 PASRR. If any resident has an acute hospitalization for mental disorder or a new diagnosis for a mental disorder is added, the interdisciplinary team will alert the Social Worker for consideration of a new PASRR.This corrective action was completed as of 3/31/25. 4. On 3/31/25 the Admission Coordinator began monitoring residents and patients scheduled to be admitted ensuring PASRRs are completed in compliance with regulations. On 3/31/25 the Social Worker began monitoring newly admitted residents to ensure PASRRs are completed in compliance with regulations. A PASRR audit will be completed weekly for 4 weeks by the Social Worker, Admissions Coordinator or designee to validate compliance. The Administrator or Social Worker will present the audit results in the monthly QAPI meeting for a minimum of three months, or as determined by the QAPI Committee. The QAPI Committee will review the results of these audits for identification of trends, action taken, and to determine the need for further monitoring and will make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 645	Continued From page 10 assessment was done if they did not receive one from the hospital. In an interview on 3/13/25 at 5:38 PM, the Administrator stated Resident #32 had a negative PASRR level I screen (a negative level I screen permits facility admission to proceed and ends the pre-screening process unless possible serious mental disorder or intellectual disability arises later) from 2017. She said the social services department was responsible for ensuring PASRR information was completed.	F 645	recommendations to assure compliance is sustained ongoing. 5. This corrective action is fully in place as of 4/4/25.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with a resident and staff, the facility failed to provide double portions as ordered by the physician and to ensure a surgeon's recommendation for a high protein diet was implemented following a surgical amputation of the resident's foot for 1 of 6 residents reviewed for therapeutic diets (Resident #56). The findings included: a. Resident #56 admitted to the facility on	F 808	1. Resident #56 is receiving double portions to include double portions of meats, starches, and vegetables. On 3/13/25 resident #56 had Physician orders written for protein supplements and vitamins, which he is receiving daily. 2.An audit was conducted on 3/31/25 by the Director of Nursing for residents with physician orders for double portions and high protein diets to ensure the dietary recommendations are implemented as written. No abnormal findings.	4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 808	Continued From page 11 1/29/25. Resident #56's comprehensive care plan initiated on 1/29/25 documented he had potential for a nutritional problem related to diagnoses of hypertension (high blood pressure), peripheral vascular disease, congestive heart failure, and type 2 diabetes mellitus, atherosclerotic heart disease, anticoagulant use, and a therapeutic diet. Interventions included to provide and serve his diet as ordered. Resident #56's physician's orders dated 1/30/25 noted he was to receive a diet of Controlled Carbohydrates and No Added Salt diet with double portions at breakfast. A significant change Minimum Data Set (MDS) dated 2/24/25 indicated Resident #56 was cognitively intact, fed himself after staff set-up assistance with meals, and received a therapeutic diet. Review of the facility's Diet Order Report dated 3/12/25 recorded Resident #56 was to receive a double portions at breakfast. An observation on 3/13/25 at 8:48 AM revealed Resident #56 with his breakfast tray. His breakfast meal had one sausage patty, two pancakes, and a 4-ounce bowl of grits. The diet slip on his tray indicated he was to receive double portions with breakfast. Double portions were not observed. In an interview on 3/13/25 at 8:49 AM, Resident #56 said he received one patty of sausage, two pancakes, and a small bowl of grits. He said he ate the grits but did not want to eat any more of	F 808	3.A) On 3/31/25 the Director of Nursing completed in-service education with the Dietary Manager related to ensuring meal tickets with double portions and high protein diets are followed as written. The Dietary Manager will in-service dietary aides on following meal tickets as printed. This education will be completed by 4/3/25. After 4/3/25 no dietary aide will be permitted to work without first receiving the preceding education by the Dietary Manager. Prior to working on the tray line, newly hired dietary aides will receive this education by the dietary manager. B) The Director of Nursing initiated in-service education for licensed nursing staff on reviewing written and transcribed consultation notes after appointments to ensure recommendations are addressed. This education will be completed by 4/3/25. After 4/3/25 no licensed nurse will be permitted to work without first receiving the preceding education by the Director of Nursing. 4. A) Weekly X 4 weeks, the Director of Nursing or designated nurse manager will complete audits of 10 resident's meal trays to ensure diet provided matches tray ticket as it relates to double portions and double proteins. B) The Director of Nursing or designated nurse manager will review consultation recommendations weekly X 4 weeks to ensure all recommendations are addressed. The Administrator or Director of Nursing will present the audit results in the monthly Quality Assurance Process Improvement (QAPI) meeting. The QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 808	Continued From page 12 his breakfast because his family would be bringing him restaurant food. In an interview on 3/13/25 at 3:14 PM, the Registered Dietitian (RD) said that Resident #56 should have received a double portion of the breakfast foods as ordered because the calories would assist with wound healing. In an interview on 3/13/25 at 4:11 PM, the Dietary Manager (DM) said that a resident with a diet order for double portions should receive double portions of meats, starches, and vegetables. He said Resident #56 should have received two sausage patties and a larger bowl of grits. The DM stated that it was an oversight that Resident #56 did not receive double portions at breakfast. In an interview on 3/13/25 at 5:05 PM, the facility Nurse Practitioner (NP) said Resident #56 had an order for double portions for his wound healing. b. Resident #56 was admitted to the facility on 1/29/25 with diagnoses including non-pressure chronic ulcer of right foot, gangrene, peripheral vascular disease, osteomyelitis (an infection in the bone) of ankle and foot, hypertension (high blood pressure), congestive heart failure, atherosclerotic heart disease and type 2 diabetes mellitus with circulatory complications. A Wound Nurse Practitioner progress note dated 2/19/25 documented Resident #56 was scheduled to have part of his right foot amputated that day. A significant change Minimum Data Set (MDS) dated 2/24/25 indicated Resident #56 was cognitively intact, fed himself after staff set-up	F 808	Committee will review the results of the audits for identification of trends, action taken and to determine the need for further monitoring and will make recommendations to assure compliance is sustained ongoing. 5. This corrective action is fully in place as of 4/4/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 808	Continued From page 13	F 808		

assistance with meals, he had a recent surgery which required skilled nursing care, received a therapeutic diet, and received anticoagulants (medications that thin the blood to prevent blood clots).

Resident #56's handwritten surgical consultation note dated 2/26/25 indicated he had a right foot transmetatarsal (the front part of the foot including the toes) amputation for dry gangrene on 2/19/25. The note included orders for antibiotics and wound care. The handwritten note did not include recommendations regarding Resident #56's diet.

Resident #56's typewritten surgical consultation report dated 2/26/25 noted the same information as was noted on the handwritten note. The typewritten report also included he should be eating a diet high in protein to aide in the healing of the surgery site.

Resident #56's nursing progress notes written by Unit Manager #1 dated 2/26/25 noted his visit with the surgeon but did not address the surgeon's recommendation for a high protein diet.

Resident #56's comprehensive care plan updated 3/01/25 documented he had potential for a nutritional problem related to diagnoses of hypertension, peripheral vascular disease, congestive heart failure, type 2 diabetes mellitus, atherosclerotic heart disease, anticoagulant use, and a therapeutic diet.

Resident #56's laboratory results dated 3/09/25 noted his albumin level was 2.9 gm/dl (normal range 3.5 to 5.5, low albumin levels can affect wound healing).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 808	Continued From page 14	F 808		

Resident #56's Registered Dietitian (RD) progress note dated 3/12/25 documented Resident #56's diet order was controlled carbohydrates, no added salt, and regular texture. The RD noted Resident #56's food intake was 0-100% in the 7 days prior. She noted he had a pressure ulcer on his right heel. The RD recommended a multivitamin daily to aid with skin integrity.

Resident #56's February and March 2025 physician's orders did not reveal orders for a high protein diet or for protein supplements.

Resident #56's February and March 2025 Medication Administration Records (MAR) did not contain entries for protein supplementation.

In an interview on 3/13/25 at 8:49 AM, Resident #56 said he did not receive any protein supplements such as an additional cup of liquids with medications or a protein milkshake.

In an interview on 3/12/25 at 2:54 PM, Unit Manager #1 reviewed Resident #56's orders and said he did not have any orders for a high protein diet or for protein supplements. She said when she reviewed the initial surgeon's consultation notes, she did not see the protein recommendation. She said she would check with medical records to see if there was another note from the physician.

During a follow up interview on 3/13/25 at 10:26 AM, Unit Manager #1 stated when Resident #56 returned from his follow up visit with the surgeon on 2/26/25, she reviewed a handwritten progress note from the surgeon which did not include the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 808	Continued From page 15	F 808		

recommendation for a high protein diet. During the interview, she reviewed the typewritten surgery consultation report dated 2/26/25 with the high protein diet recommendation. She said when a resident saw an outside consultant provider, the provider would sometimes send the facility two notes, a handwritten one done immediately while the resident was at the clinic and another one, usually when information was dictated, that would be faxed to the facility for the chart. The high protein diet recommendation was faxed over from the surgeon on 2/27/25 and she did not see it. She said the Medical Records Coordinator would receive any additional typewritten notes from a provider and upload the notes to the chart. She said she did not normally see the typewritten notes and said she did not know the notes could contain different or additional information. She said a high protein diet would help with Resident #56's wound healing but the recommendation was just missed because it was not on the original handwritten note. Unit Manager #1 reviewed Resident #56's physician orders and said there were no protein supplements ordered and there were no changes to his diet order since 1/30/25 when the double portions with breakfast was ordered. She said the facility had multiple supplements that could have been added to Resident #56's regimen but had not been ordered.

In an interview on 3/13/25 at 3:14 PM, the RD said if diet changes were made at an outside consultant appointment, she would be made aware by nursing or when the report was put into the resident's clinical record. She said she had not reviewed the surgeon's progress notes from the 2/26/25 visit and was not sure if it was uploaded into the chart when she reviewed his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 808	Continued From page 16 chart on 3/12/25. She said she did not know about the recommendation for a high protein diet. She said she did not want to comment on Resident #56's specific case re: protein and if it was beneficial for him because she did not remember the details. She saw Resident #56 the day he went out for surgery but did not have another note until 3/12/25. In an interview on 3/13/25 at 4:08 PM, the Director of Nursing (DON) said Resident #56 received double portions of breakfast but she was not aware of the recommendation of a high protein diet from the surgeon. In an interview on 3/13/25 at 4:34 PM, Nurse Practitioner #1 said she was not aware of the recommendation from the surgeon until 3/13/25. She said having Resident #56 on a high protein diet would be a proactive intervention to aide in long-term wound healing. She indicated Resident #56 did not eat much of the facility food but that his family frequently brought in food for him which he ate. She added that the resident's albumin level had increased, indicating he was getting enough protein.	F 808		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 812	Continued From page 17 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food items stored for use in 1 of 1 walk-in refrigerator and failed to serve a hot food item at a safe temperature range (at or above 135 degrees Fahrenheit) to prevent the potential for food borne illness for 1 of 1 meal observations. These practices had the potential to affect food served to residents. The findings included: 1. Observation on 3/10/25 at 10:47 AM of the walk-in refrigerator revealed 10 yogurt containers with an expiration date of 2/27/25 on the shelf. In an interview on 3/10/25 at 10:48 AM, the Dietary Manager (DM) said he had just put the yogurt containers on the shelf in order to take them to the halls for the residents but confirmed they were expired. He said normally the person putting away the delivery each week would check, and he (the DM) would double check dates throughout the week but just missed the yogurt. Observation on 3/13/25 at 3:10 PM of the walk-in refrigerator revealed two 5-pound tubs of sour cream and two 32 ounce containers of yogurt on	F 812	1. Both the yogurt and the sour cream were disposed of on 3/14/25 when the Dietary Manager became aware of the expiration dates. The mashed potatoes were removed from the steam table, reheated and brought to the appropriate gtemperature prior to serviing to the residents on 3/12/25. 2. All residents are at risk if fed expired or out of range temperature foods. No residents have experienced food born illness or expressed concern about foods that are not hot enough. Residents who would express this concern will be provided with a fresh tray of food which has been verified fresh and served at proper temperature. Temperatures are monitored during meal preparation and meal service to assure each meets the standards required for safe and palatable food distribution. Stored food, both cooled and dry storage, were examined to assure that no other outdated or nearly outdated, food was available for use. No other expired food was identified. The vendor's regional representative was contacted on 3/17/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 812	Continued From page 18 the shelf. One tub of the sour cream had been open and used. The manufacturer's label on the sour cream read, "Best if used by 2/07/25" and a label on the top with handwritten dates for the two tubs to be used 3/08/25 and 3/14/25. The two 32-ounce tubs of yogurt were unopened with an expiration date 2/11/25 with a handwritten date of 3/05/25 on the lid. In an interview on 3/13/25 at 4:11 PM, the DM stated the sour cream had a best if used by date, which was not an expiration date, and the label date of 3/08/25 was the date it was opened. He said they were out of date and should have been removed. He said the handwritten date on the yogurt lid was the day it was delivered from the food distributor. He was not sure why the expiration date was not verified when the yogurt was delivered. 2. Observation on 3/12/25 at 12:17 PM revealed Cook #1 take the temperature of a pan of mashed potatoes on the steam table using a digital thermometer. The temperature of the potatoes was 111 degrees Fahrenheit (F). Cook #1 then stirred the mashed potatoes and took the temperature again. The temperature was 113 degrees F. In an interview on 3/12/25 at 12:18 PM, Cook #1 said the mashed potatoes should have maintained a temperature of at least 145 degrees F while on the steam table. In an interview on 3/12/25 at 12:19 PM, the DM told Cook #1 the mashed potatoes needed to be removed from the steam table and heated to temperature.	F 812	about the food that ha been received out of date or writhin only the "best used by" date range. 3. On 3/14/25 the Nursing Home Administrator educated the Dietary Manager on the correct management of product dates, use by dates, and labeling and dating of foods upon receipt and/or opening. Dietary staff were inserviced by 4/3/25 by the dietary manager regarding the correct management of product dates, use by dates and labeling and dating of foods upon receipt and/or opening. Upon receipt, all foods, whether chilled, frozen or dry stored are examined for current freshness dates and marked with the date received or opened, to assure ongoing freshness. Dietary staff in-service included re-checking these dates prior to use or serving. The cooks were in-serviced by the dietary manager on 4/3/25 regarding the importance of stirring and monitoring food temperatures to assure temperatures are maintained at required levels prior to serving. The in-service stipulates that any drop in temperature that causes food temperature to be out of acceptable range requires the food not to be served until or unless it can be brought to the appropriate temperature prior to serving. All new dietary employees will be educated on managing and labeling dates and proper cooking and serving temperatures during orientation and periodically to assure sustained compliance. 4. The cook will record food temperatures three times per meal period to assure temperature standards are maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 812	Continued From page 19 In a continuous observation on 3/12/25 from 12:19 PM to 12:25 PM revealed Cook #1 begin to plate food items for service. The pan of mashed potatoes had not been removed from the steam table to reheat but had not been plated. Observation on 3/12/25 at 12:25 PM, Cook #1 scooped mashed potatoes onto a plate for service from the same pan. She continued to plate a puree diet plate and handed it to the dietary aide for service. After surveyor intervention, the plate was not served. The DM asked Cook #1 to get a spoon and stir the potatoes and retake the temperature. Observation on 3/12/25 at 12:26 PM, Cook #1 removed the pan of mashed potatoes from the steam table, stirred them, and retook the temperature, which read 122 degrees F. Cook #1 continued to stir the potatoes and at 12:27 PM, she retook the temperature, which read 127 degrees F. The DM got a large pot of boiling water to reheat the potatoes. Observation on 3/12/25 at 12:28 PM, Cook #1 stirred the mashed potatoes and took the temperature. The temperature was 141 degrees F. The mashed potatoes were returned to the steam table for service and service resumed. In an interview on 3/12/25 at 12:28 PM, Cook #1 said she did not remove the pan of mashed potatoes when it was not at holding temperature because she "didn't think about it." In an interview on 3/12/25 at 1:10 PM, the DM said the mashed potatoes should have been removed from the tray line when the temperature was too low to be cooked longer before serving to	F 812	Should food temperature drop, the cook will stir the food and retake the temperature, then reheat if needed to bring back into the proper range and will continue to monitor to assure the proper temperature is sustained. The Dietary Manager will review the temperature logs and meal service tray line 3X per week to assure compliance and understanding and will provide the results of this auditing to the QAPI committee monthly for a minimum of 3 months or until the committee determines compliance has been sustained. 5. The corrective action is fully in place as of 4/4/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	**1804 FOREST HILLS ROAD W WILSON, NC 27893**

(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 812	Continued From page 20 the residents.	F 812		