STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, and staff interview, the facility failed to notify the Responsible Party (RP) of abnormal laboratory results and a subsequent new medication order for Resident #1. This was for 1 of 4 residents reviewed for notification of change. The findings included: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 ' s Responsible Party (RP) was a family member. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 ' s cognition was severely impaired. Laboratory (lab) results dated 7/1/20 indicated Resident #1 ' s Vitamin B-12 level was low at 154 (reference range 180-914). A physician's order [REDACTED]. The start date was 7/3/20 and the end date was 7/5/20. Resident #1 ' s July 2020 Medication Administration Record [REDACTED]. A nursing note dated 7/6/20 indicated Resident #1 ' s RP contacted the facility to check on her status. The note indicated the RP was explained that Resident #1 was on the [MEDICATION NAME] injection for 3 days (7/3/20, 7/4/20, and 7/5/20) and then was going to receive the medication monthly due to a low B-12 level when she had her labs taken the prior week. The nursing note further indicated that Resident #1 ' s RP said that she'd like to know of any changes with Resident #1 including her medication orders. An Authorization for Use and Disclosure of Protected Health Information form dated 7/7/20 indicated Resident #1 ' s RP requested access to lab reports and the MAR for 5/18/20 (admitted) through 7/7/20 for the purpose of following up on the resident. A phone interview was conducted with Resident #1 ' s RP on 9/4/20 at 9:45 AM. She stated that she was Resident #1 ' s RP. She indicated that since Resident #1 was admitted to the facility (5/18/20) she has frequently completed window visits to observe the resident from outside of the facility due to the visiting restrictions related to the COVID-19 pandemic. She reported that she was very involved in Resident ' s #1 ' s care and treatment decisions and she spoke regularly with the Director of Nursing (DON) by phone and electronic correspondence. Resident #1 ' s RP revealed a concern with notification of treatment changes for the resident. She stated that sometime in early July 2020 she phoned the facility to receive an update on Resident #1 and during the phone call the nurse mentioned that the resident was administered her B-12 injection. The RP reported that this was the first time anyone mentioned a B-12 injection and she was concerned that facility staff had not notified her of the physician's order [REDACTED]. She explained that during the phone call the nurse also informed her of the 7/1/20 lab results that revealed a low B-12 level for Resident #1. The RP stated that after that phone call she requested Resident #1 ' s medical records to review the lab reports and MARs as she was concerned there was other information she had not been informed of. She indicated that the facility required her to sign a form for release of these records prior to providing her with this information. An interview was conducted with the DON on 9/3/20 at 2:40 PM. The DON reported that she spoke with Resident #1 ' s RP frequently by phone and/or email correspondence. She explained that Resident #1 ' s RP was very involved with the resident ' s care and that she regularly contacted her to speak about concerns, issues, and/or requests. Resident #1 ' s lab results dated 7/1/20 that revealed a low B-12 level and the physician's order [REDACTED]. The nursing note dated 7/6/20 that indicated Resident #1 ' s RP was explained that she received the [MEDICATION NAME] injection for 3 days related to a low B-12 level from the 7/1/20 labs was reviewed with the DON. The DON was asked why Resident #1 ' s RP was not notified of the abnormal labs and the new order for the [MEDICATION NAME] injection prior to the administration of the medication. The DON stated that she had not viewed this information as a significant change. She explained that most family members were not as involved as Resident #1 ' s RP and had not wanted to be called for every medication change. She indicated that looking back on the incident she should have notified Resident #1 ' s RP of the abnormal lab results and the physician's order [REDACTED]. During a follow up interview with the DON on 9/3/20 at 3:56 PM she stated that it was ultimately her responsibility to ensure notifications of change were completed as required in accordance with the regulations.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, and staff interview, the facility failed to report a confirmed COVID-19 infection for Resident #5 to her Responsibility Party (RP) and also failed to report cumulative updates on subsequent confirmed COVID-19 infections for other residents within the facility to the RP as required. This was for 1 of 4 residents reviewed for COVID-19 reporting. The findings included: Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#5 ' s cognition was severely impaired. A nursing date dated 8/22/20 indicated Resident #5 ' s Responsible Party (RP) was notified by phone that her COVID-19 test results were negative. The RP was informed that Resident #5 would be retested the following week. The medical record revealed no further communication with Resident #5 ' s RP related to COVID-19 testing. The facility ' s resident list of confirmed positive COVID-19 infections was provided by the Infection Control Preventionist on 9/3/20. The list revealed 35 current residents out of 69 had confirmed positive COVID-19 infections identified during testing that occurred from 8/21/20 through 8/28/20. This list indicated that Resident #5 was confirmed positive for COVID-19. A phone interview was conducted with Resident #5 ' s RP on 9/4/20 at 12:38 PM. He stated that he was contacted by facility staff on 8/22/20 and was told there were residents in the facility who had tested positive for COVID-19. He indicated he was informed Resident #5 was tested on [DATE] with negative results. He reported staff also informed him Resident #5 would be retested within the next week. Resident #5 ' s RP revealed he had no further correspondence from facility staff after 8/22/20. He stated that he was not informed of the results from Resident #5 ' s COVID-19 test that was supposed to take place the week after 8/22/20 nor was he provided with any cumulative update on the facility ' s COVID-19 infection status since 8/22/20. An interview was conducted with the Social Worker (SW) on 9/3/20 at 10:20 AM. The SW indicated that the first facility resident with a confirmed COVID-19 infection was identified on 8/21/20. She stated that prior to 8/21/20 she was responsible for weekly notifications to residents ' RPs by phone to report on the facility ' s COVID-19 infection status. The SW explained that these weekly phone calls provided general information to the RPs reporting that there were no residents in the facility that had confirmed COVID-19 infections. She further explained that mass testing began on 8/21/20 and since that time she and the Director of Nursing (DON) were making notifications by phone to inform RPs of COVID-19 test results for the facility resident who they were responsible for. An interview was conducted with the DON on 9/3/20 at 3:50 PM. The DON stated that a resident (Resident #6) was sent out to the hospital for a change in condition on 8/20/20 and tested positive for COVID-19 while at the hospital. She indicated that this was the first resident from the facility who was confirmed positive for COVID-19. She reported that mass resident testing was conducted on 8/21/20 with all results being received by 8/22/20. The DON explained that she and the SW began contacting RPs by phone on 8/21/20 through 8/22/20 to inform them of the facility ' s current COVID-19 status as well as test results for the facility resident who they were responsible for. She further explained that the RPs of residents with negative COVID-19 test results were informed the test would be repeated the following week. This interview with the DON continued. She reported that Resident #5 tested negative for COVID-19 on 8/21/20. She indicated that Resident #5 ' s RP was notified by

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

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

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F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) phone on 8/22/20 that there were confirmed positive COVID-19 residents within the facility and that Resident #5 was tested on [DATE] with negative results. The DON reported that on 8/23/20 Resident #5 ' s repeat testing revealed a confirmed COVID-19 infection. The DON was asked if she reported Resident #5 ' s COVID-19 test results and/or cumulative updates on the facility ' s COVID-19 infection status to Resident #5 ' s RP after her 8/23/20 test results confirmed a COVID-19 infection and she revealed that she couldn ' t recall. The DON indicated that there was a lot going on at the facility since the first confirmed positive COVID-19 resident was identified (8/21/20) and that this correspondence to Resident #5 ' s RP could have been missed. A follow up interview was conducted with the SW on 9/3/20 at 3:55 PM. The SW revealed that she could not recall if she reported Resident #5 ' s COVID-19 test results and/or cumulative updates on the facility ' s COVID-19 infection status to Resident #5 ' s RP after her 8/23/20 test results confirmed a COVID-19 infection. On 9/3/20 at 3:56 PM the DON stated that ultimately it was her responsibility to ensure COVID-19 reporting was made to each residents ' RP in accordance with the regulations.