STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 recertification and complaint investigation survey was conducted from 06/03/24 through 06/07/24. The team returned to the facility on 06/13/24 to validate the credible allegations of IJ removal therefore, the exit date was changed to 06/13/24. The facility was found out of compliance with the requirement CFR.483.73, Emergency Preparedness. Event ID #3J5P11.	E 000		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E 037		7/17/24

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

Electronically Signed | 06/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 037	Continued From page 1	E 037		

procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 2	E 037		

procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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E 037	Continued From page 3	E 037		

preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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E 037	Continued From page 4 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to maintain an Emergency Preparedness program that met the requirements for initial emergency preparedness training for the Emergency Preparedness (EP) Plan for 7 of 7 staff members reviewed for emergency preparedness (Staff Development Coordinator, Nurse #4, Nurse Aide #3, #4, #5, #7, #13). The findings included: A review of the facility's Emergency Preparedness (EP) manual revealed the date last reviewed on 08/23/23.	E 037	Staff Development Coordinator and NA#5 are no longer working at the facility. Nurse #4, Nurse Aide #3, #4, #7, and #13 will be educated by the Administrator on the Emergency Preparedness (EP) Plan by 7/16/24. The Director of Operations educated the Administrator/ Director of Nursing on the Emergency Preparedness (EP) plan on 6/27/2024. The Director of Nursing (DON)/ Administrator will ensure that the facility staff to include licensed nurses, certified nursing assistants (CNA),certified medication assistants (CMA), therapists,	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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E 037	Continued From page 5 a. A review of the personnel file and training file of the Staff Development Coordinator (SDC) revealed the SDC was hired 05/22/24 and the files contained no proof that she received EP education. During an interview with the SDC on 06/05/24 at 11:11 AM the SCD indicated she did not receive EP training during orientation upon hire. b. A review of Nurse #4's personnel file and training file revealed she was hired 03/06/24 and the files contained no proof that she received EP education. An interview with Nurse #4 was conducted on 06/06/24 at 8:56 AM. The Nurse indicated she did not receive EP training given by the facility in orientation. c. A review of Nurse Aide (NA) #3's personnel file and training file revealed he was hired on 04/24/24 and the files contained no proof that he received EP education. During an interview conducted with NA #3 on 06/07/24 at 4:16 PM the NA reported he did not receive training on EP in orientation. d. A review of NA #4's personnel file and training file revealed he was hired 05/22/24 and the files contained no proof that he received EP education. On 06/13/24 at 9:53 AM an interview was conducted with NA #4 who explained he received training on EP during orientation, but he could not remember what he was trained on.	E 037	housekeeping/laundry staff, dietary staff, social services staff, administrative staff, weekend staff, agency, new hires, and prn staff will be educated by 7/16/24 on the Emergency Preparedness Plan. Staff will not be allowed to work without completing the education. The EP Training Program will be included in new staff orientation. The Administrator will be responsible for ensuring audits are completed weekly x 4 weeks and monthly x 2 months of the facility staff to include new hires during orientation to ensure the EP plan education continues to be completed. The Administrator will report the findings monthly for at least 6 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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E 037	Continued From page 6	E 037		

e. A review of NA #5's personnel file and training file revealed he was hired 05/01/24 and the files contained no proof that he received EP education.

An interview was conducted with NA #5 on 06/03/24 at 1:53 PM revealed he did not receive EP education and training during orientation.

f. A review of NA #7's personnel file and training file revealed she was hired on 05/01/24 and the files contained no proof that he received EP education.

On 06/07/24 at 3:25 PM an interview was conducted with NA #7 revealed she did not receive training on EP during orientation.

g. A review of NA #13's personnel file and training file revealed she was hired on 05/29/24 and the file contained no proof that he received EP education.

An interview conducted with NA #13 on 06/07/24 at 4:16 PM revealed she did not receive training on EP during orientation.

An interview conducted with the Administrator on 06/07/24 at 12:22 PM and 06/13/24 at 4:46 PM revealed the Administrator explained he had only been employed at the facility for a few months and immediately identified issues of concern that needed his immediate attention and began solving those issues first. He stated the last Staff Development Coordinator (SDC) did not work out, so they had to hire a new SDC that had only been employed a few days and had not gotten a chance to get herself acclimated to her job

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E 037	Continued From page 7 description. He indicated he was not aware of the lack of EP training.	E 037		
F 000	INITIAL COMMENTS A recertification and compliant investigation survey was conducted from 06/03/24 through 06/07/24. The survey team returned to the facility on 06/13/24 to validate the credible allegations of IJ removal. Therefore, the exit date was changed to 06/13/24. The following intakes were investigated: NC00204864, NC00205045, NC00205034, NC00205265, NC00217718, NC00208083, NC00210573, NC00211668, NC00212371, NC00214330, NC00214720 and NC00217379. Thirteen (13) of the 27 complaint allegations resulted in deficiencies. Event ID #3J5P11. Immediate Jeopardy was identified at: CFR 483.12 at tag 600 at a scope and severity (J) Immediate Jeopardy began on 05/27/24 and removed on 06/12/24. CFR 483.24 at tag 678 at a scope and severity (J) Immediate Jeopardy began on 06/03/24 and removed on 06/12/24. CFR 483.25 at tag 684 at a scope and severity (J) Immediate Jeopardy began on 05/27/24 and removed on 06/12/24. CFR 483.25 at tag 697 at a scope and severity (J) Immediate Jeopardy began on 05/27/24 and removed on 06/10/24. CFR 483.35 at tag 726 at a scope and severity (K) Immediate Jeopardy began on 06/03/24 and removed on 06/12/24. An extended survey was conducted.	F 000		
F 554	Resident Self-Admin Meds-Clinically Approp	F 554		7/17/24

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F 554 SS=D	Continued From page 8 CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Resident interviews, the facility failed to assess Resident #99 for the ability to self-administer medications for 1 of 1 Resident reviewed for self-administering medications. The finding included: Resident #99 was admitted to the facility on 05/29/24. A review of Resident #99's physician orders revealed orders for Fluticasone Propionate Nasal Suspension one puff in both nostrils two times a day for allergies dated 05/29/24, Albuterol Sulfate HFA Aerosol Solution, give one puff orally every 6 hours as needed for shortness of breath or wheezing dated 05/29/24. There was no physician order to self-medicate. There was no order for the Budesonide-Glycopyrrolate-Formoterol Fumarate inhaler, fiber tablets or antacid tablets. The admission Minimum Data Set assessment dated 06/03/24 indicated Resident #99 was cognitively intact. A review of Resident #99's medical record revealed there was no assessment to self-administer medications.	F 554	Resident #99 medications were removed from the room by the Director of Nursing on 6/7/24. Resident #99 declined assessment for self-administration. Resident #99 was discharged from the facility on 6/8/24 and the identified medication was returned to her on discharge. Current residents are at risk for this deficient practice. On 6/27/24, the Director of Nursing/ Unit Manager began auditing current residents' rooms to determine if medications were identified at the bedside. No additional medications have been removed from resident rooms. Starting 6/15/24, the Director of Nursing/Unit Manager begin educating the licensed nurses to include agency/ contracted, new hires and prn staff regarding self-administration medication assessments, obtaining physician orders and care planning. Starting 6/27/24, the Director of Nursing/ Unit Manager begin educating the facility staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), therapists, housekeeping/laundry staff, dietary staff, social services staff, administrative staff,	

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F 554	Continued From page 9 On 06/03/24 at 12:09 PM during an interview and observation of Resident #99, it was noted that there was an Albuterol inhaler, two bottles of fiber tablet supplements, one bottle of Fluticasone Propionate nasal spray, and one bottle of antacid tablets on her over bed table. In addition, there was a Budesonide-Glycopyrrolate-Formoterol Fumarate inhaler on the table next to the bathroom door. The Resident explained that she had breathing problems, and she kept the albuterol inhaler close to her in case she had to use it as a rescue inhaler. She stated her sister brought her medications (the 2 inhalers, the 2 bottles of fiber tablets, the nasal spray and the bottle of antacid tablets) to her the day after she was admitted to the facility. An interview was conducted with Medication Aide (MA) #2 on 06/04/24 at 9:44 AM during a medication pass. The MA asked Resident #99 if she administered her nasal spray and inhaler and the Resident replied yes. The MA explained that Resident #99 kept her nasal spray (Fluticasone) and inhaler (Albuterol) in her room and administered the medications on her own. The MA indicated the Resident had an order to self-medicate. A subsequent observation made on 06/04/24 at 10:00 AM revealed the above-described medications remained in the Resident's room. An interview was conducted with the Supervisor on 06/06/24 at 12:36 PM who explained that the residents could not keep their medication at their bedside unless they had been assessed as being able to self-medicate. She stated she did not know of any resident that was currently able to self-medicate and keep their medicine in their	F 554	weekend staff, agency, new hires, and prn staff on reporting identified medications at residents bedside to the licensed nurse. The Director of Nursing (DON)/ Unit Manager will ensure that all current staff to include agency and prn staff who have not received this education by 7/16/24 will not be allowed to work until the education is completed. The Director of Nursing/ Unit Manager will ensure newly hired staff to include agency/ contracted staff will receive education during the facility orientation in person or via telephone prior to working. The Director of Nursing will complete audits weekly for 4 weeks and monthly for 2 months to ensure continual compliance. The Director of Nursing will report the findings monthly for at least 6 months to the Quality Assurance Performance Improvement (QAPI) committee for review and/or revision.	

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F 554	Continued From page 10 room. An interview was conducted with the Director of Nursing on 06/07/24 at 9:38 AM who explained that the residents had to be assessed to be able to self-medicate safely and at the present time there were no residents that were allowed to self-medicate. She stated they removed Resident #99's medications from her room and the medications would be given back to her on her discharge which was scheduled for 06/08/24. The DON stated they offered to assess Resident #99 to be able to self-medicate but she declined since she would be discharged on 06/08/24.	F 554		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 11 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and review of the facility's Advance Directive policy the facility failed to provide written advance directive information and/or opportunity to formulate an advance directive and also failed to ensure a resident's code status election was evident and accurately documented in the medical record for 6 of 6 (Resident #81, #83, #86, #68, #32, and #72) residents reviewed for advance directive. Findings included: 1. Resident #81 was admitted to the facility on 02/24/23. A review of Resident #81's electronic health record revealed an advanced directive order for Full Code dated 02/24/23.	F 578	Residents #81. #83, #86, #68, #32, #72 advanced directives were completed by the provider on 6/7/24, scanned into the medical record and placed in the Code Status notebook. The current residents are at risk for this deficient practice. On 6/10/24, social services completed an advanced directive audit, and 10 resident advanced directives were updated by the provider. Starting 6/10/24, social services and the facility medical providers were educated by the Director of Nursing on ensuring that residents' advanced directives are completed, scanned into the medical record and placed in the Code Status notebook. The Director of Nursing will ensure newly hired/ prn social service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 578	Continued From page 12 A review of Resident #81's quarterly Minimum Data Set assessment dated 05/29/24 revealed Resident #81 was severely cognitively impaired. A review of the Code Status notebook maintained at the nursing desk on 06/04/24 revealed there was no advanced directive in the code status notebook for Resident #81. During an interview with the Physician Assistant (PA) on 06/04/24 5:34 PM she explained that she addressed the residents' advanced directives after they were admitted and completed the Medical Order for Scope of Treatment (MOST) and Do Not Resuscitate (DNR) forms then gave the forms to the Director of Nursing to put in the Code State notebook. The PA stated she had not completed Resident #81's advanced directive paperwork yet because the Resident's cognition was impaired, and she had been unable to connect with his family. An interview was conducted with the Director of Nursing (DON) on 06/08/24 at 9:38 AM. The DON reported the PA addressed the residents' advanced directives when they were admitted to the facility and the paperwork was placed in the code status notebook at the nursing desk. The DON stated she was not aware that Resident #81's advanced directive forms had not been placed in the code status notebook and remarked that the Resident had been in the facility long enough for the paperwork to be completed. 2. Resident #83 was readmitted to the facility on 07/21/23. A review of Resident #83's electronic health	F 578	staff, new providers will receive this education prior to working in the facility. The Director of Nursing will complete audits weekly x4 weeks and monthly x 2 months to ensure advanced directives continue to be completed by the provider, scanned in the medical record and place in the Code Status notebook. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement Committee for review and/or revisions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 578	Continued From page 13	F 578		

record revealed an advanced directive order for Do Not Resuscitate (DNR) dated 11/09/23.

Review of a care plan revised on 12/26/23 read, Advance Directive, Full Code. The intervention stated advance directives will be followed as ordered.

A review of Resident #83's quarterly Minimum Data Set assessment dated 03/19/24 revealed Resident #83 was cognitively intact.

A review of the Code Status notebook maintained at the nursing desk on 06/04/24 revealed there was no advanced directive in the code status notebook for Resident #83.

Social Worker (SW) #1 was interviewed on 06/04/24 at 2:01 PM. She confirmed that she was responsible for updating advance directive care plans. She explained that the medical provider addressed advance directives upon admission and then it was discussed with each care plan meeting or as needed. SW #1 stated she was not sure how Resident #83's care plan was missed when updating his other care plan but stated she would correct it promptly.

During an interview with the Physician Assistant (PA) on 06/04/24 5:34 PM she explained that she addressed the residents' advanced directives after they were admitted and completed the Medical Order for Scope of Treatment (MOST) and Do Not Resuscitate (DNR) forms then gave the forms to the Director of Nursing to put in the Code State notebook. The PA was not sure why Resident #83's advance directive paperwork was not where it should be but stated it may not have come back from the hospital with him and she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 578	Continued From page 14	F 578		

would need readdress that with him.

An interview was conducted with the Director of Nursing (DON) on 06/08/24 at 9:38 AM. The DON reported the PA addressed the residents' advanced directives when they were admitted to the facility and the paperwork was placed in the code status notebook at the nursing desk. The DON stated she was not aware that Resident #83's advanced directive forms had not been placed in the code status notebook and that his care plan had not been updated. The DON remarked that the Resident had been in the facility long enough for the paperwork to be completed and his care plan to have been revised.

3. Resident #86 was admitted to the facility on 04/06/24.

A review of Resident #86's electronic health record revealed an advanced directive order for Full Code dated 04/06/24.

A review of Resident #86's Admission Minimum Data Set assessment dated 04/12/24 revealed Resident #86 was severely cognitively impaired.

A review of the Code Status notebook maintained at the nursing desk on 06/04/24 revealed there was no advanced directive in the code status notebook for Resident #86.

During an interview with the Physician Assistant (PA) on 06/04/24 5:34 PM she explained that she addressed the residents' advanced directives after they were admitted and completed the Medical Order for Scope of Treatment (MOST) and Do Not Resuscitate (DNR) forms then gave

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 578	Continued From page 15	F 578		

the forms to the Director of Nursing to put in the Code State notebook. The PA stated she had not completed Resident #86's advanced directive paperwork yet because the Resident's cognition was impaired, and she had needed to connect with her family.

An interview was conducted with the Director of Nursing (DON) on 06/08/24 at 9:38 AM. The DON reported the PA addressed the residents' advanced directives when they were admitted to the facility and the paperwork was placed in the code status notebook at the nursing desk. The DON stated she was not aware that Resident #86's advanced directive forms had not been placed in the code status notebook and remarked that the Resident had been in the facility long enough for the paperwork to be completed.

4. Resident #68 was admitted to the facility on 2/28/2023.

A review of the facility's code status book revealed Resident #68 had a MOST form dated 7/13/2023 and was a full code with full scope of treatment to include intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, intravenous fluids, and to transfer to the hospital if indicated and was signed by PA #1.

A review of a physician's order dated 7/13/2023 revealed Resident #68 was a full code and "Do Not Intubate (DNI)."

An annual Minimum Data Set (MDS) dated 3/5/2024 revealed Resident #68 was moderately impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 578	Continued From page 16	F 578		

A review of a care plan dated 3/5/2024 revealed Resident #68 wished to be a full code.
An interview was conducted on 6/4/2024 at 2:01 pm with Social Worker (SW) #1. SW #1 reported when a resident was admitted, she would enter that information into the Electronic Health Record (EHR). SW #1 stated PA #1 discusses code status with the resident and their family upon admission and stated PA #1 completed the MOST form. SW #1 stated the MOST form should match the physician's orders.

An interview was conducted on 6/4/2024 at 3:31 pm with PA #1. PA #1 reported she addressed code status with residents and their families upon admission to the facility and routinely addresses code status as changes arise. PA #1 stated she completed MOST forms after she had spoken with the resident and explained the document in detail. PA #1 stated if a resident was a full code and DNI, the MOST form should indicate to initiate chest compressions and to perform limited interventions. PA #1 verified Resident #68 had a physician's order for full code and DNI. PA #1 reported that was an error because she was not able to recall Resident #68 requesting to not be intubated.

A follow-up interview was conducted on 6/4/2024 at 4:16 pm with PA #1. PA #1 had spoken with Resident #68, and she had requested to be a full code with all interventions completed. She reported she had entered the physician's order in the EHR incorrectly.

An interview was conducted on 6/7/2024 at 8:27 am with the Director of Nursing (DON). The DON stated PA #1 primarily completed the MOST forms when a resident was admitted to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 578	Continued From page 17	F 578		

or if the resident had changes in condition. The DON was not aware Resident #68 had an order for full code and DNI, and agreed the MOST form and the physician's orders should match.

An interview was conducted on 6/7/2024 at 3:13 pm with the Administrator. The Administrator was not aware that the physician's orders and MOST form had not matched for Resident #68, and agreed they should have. The Administrator was not aware that PA #1 was solely responsible for completing the MOST form and indicated SW should be participating in this process as well.

5. Resident #32 was admitted to the facility on 11/15/23.

A review of Resident #32's electronic health record revealed an advanced directive order for Full Code
dated 11/20/23.

A review of Resident #32's Minimum Data Set assessment dated 05/11/24 revealed she was cognitively intact.

A review of the Code Status notebook maintained at the nursing desk on 06/04/24 at 1:56 PM revealed there was no advanced directive in the code status notebook for Resident #32.

During an interview with the Physician Assistant (PA) on 06/04/24 5:02 PM she explained that she addressed the residents' advanced directives after they were admitted and completed the Medical Order for Scope of Treatment (MOST) and Do Not Resuscitate (DNR) forms then gave the forms to the Director of Nursing to put in the Code State notebook. The PA stated she had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 578	Continued From page 18	F 578		

completed Resident #32's advanced directive paperwork yet because the Resident's cognition wavered, and she had not found her stable enough to address it with her.

An interview was conducted with the Director of Nursing (DON) on 06/08/24 at 9:38 AM. The DON reported the PA addressed the residents' advanced directives when they were admitted to the facility and the paperwork was placed in the code status notebook at the nursing desk. The DON stated she was not aware that Resident #32's advanced directive forms had not been placed in the code status notebook and remarked that the Resident had been in the facility long enough for the paperwork to be completed.

6. Resident #72 was admitted to the facility on 09/29/23.

A review of Resident #72's electronic health record (EHR) revealed an advanced directive order for Full Code dated 01/09/24.

A review of Resident #72's Minimum Data Set assessment dated 04/01/24 revealed her cognition was moderately impaired.

A review of the Code Status notebook maintained at the nursing desk on 06/03/24 at 7:31 PM revealed there was no advanced directive in the code status notebook for Resident #72.

On 06/04/24 at 4:42 PM an interview was conducted with the Physician Assistant (PA) who explained that she addressed the residents' advanced directives after they were admitted and completed the MOST and DNR forms then gave the forms to the Director of Nursing to put in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 578	Continued From page 19 Code Status notebook. The PA stated she had not completed Resident #72's advanced directive paperwork yet because she was just this last week or two been able to talk with the Resident's responsible party who was the Resident's guardian and she had not been able to complete the process. During an interview with the Director of Nursing (DON) on 06/07/24 at 10:03 AM the DON reported the PA addressed the residents' advanced directives when they were admitted to the facility and the paperwork was placed in the code status notebook at the nursing desk. The DON stated she was not aware that Resident #72's advanced directive forms had not been placed in the code status notebook and remarked that the Resident had been in the facility long enough for the paperwork to be completed.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 580	Continued From page 20 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician Assistant (PA), and Medical Director (MD) interviews the facility failed to notify the provider that the ordered laboratory testing was not obtained for 1 of 2 residents (Resident #196) reviewed for notification of change.	F 580	Resident #196 refused labs on 12/26/23 and was discharged to the hospital on 12/26/23. Current residents requiring laboratory testing are at risk for this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 580	Continued From page 21 The findings included: Resident #196 was admitted to the facility on 12/18/2023 with a diagnosis of respiratory failure. A review of the 5-day Minimum Data Set (MDS) dated 12/25/2023 revealed Resident #196 was severely cognitively impaired with no behaviors. Review of a physician order dated 12/25/2023 read; Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) related to increased confusion per family members observation. A review of the December 2023 progress notes revealed no progress note indicating a medical provider was made aware of laboratory results or the inability to obtain laboratory results. A review of the Resident #196's December 2023 Medication Administration Record (MAR) indicated Nurse #6 had collected a CBC and BMP on 12/25/2023 at 1:24 am. An interview was conducted on 6/4/2024 at 8:36 pm with Nurse #6. Nurse #6 reported she worked on 12/24/2023 during the night shift (7:00 pm to 7:00 am) and was assigned Resident #196. Nurse #6 stated after she had started her shift, Resident #196's Representative (RR) reported Resident #196 had acted more confused. Nurse #6 stated she called the provider on-call and was given orders to obtain laboratory testing. Nurse #6 reported she had not obtained laboratory testing that night because she never drew blood at night and was not able to draw blood. Nurse #6 was not able to recall documenting that she had collected Resident #196's labs, and was not	F 580	By 7/2/24, the Director of Nursing will complete audits of the laboratory test ordered in the last 30 days to ensure labs are being completed as required and the provider is being notified of laboratory test results. The Director of Nursing/ Unit Manager will educate the licensed nurses to include agency and prn licensed nurses on ensuring that laboratory tests are being completed as ordered and laboratory results, refusals, and/or labs that were not obtained are being reported to the provider and/or the responsible parties. Licensed nurses are documenting residents' refusals, labs obtained, and labs that were not obtained in the progress notes. Newly hired license nurses will not be allowed to work until the education is completed. The laboratory procedure will be included in the new agency orientation binder and the Unit Manager/supervisor will educate any new agency licensed nursing staff. The Director of Nursing will complete audits of laboratory tests 2 x a week for 4 weeks and weekly for 4 weeks and monthly for 2 months to ensure continued compliance. The Director of Nursing will report the finding to the Quality Assurance Performance Committee for review and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 580	Continued From page 22	F 580		

sure why it was documented that she had on the MAR.

An interview was conducted on 6/4/2024 at 10:23 am with Nurse #5. Nurse #5 reported she had worked on 12/25/2023 during dayshift (7:00 am to 7:00 pm) and was assigned Resident #196. Nurse #5 reported she had not collected laboratory testing on Resident #196 because she was not prompted to do so on the computer system used in the facility. Nurse #5 stated she thought the labs had been completed since Nurse #6 had checked the collection off on the MAR. Nurse #5 verified Resident #196's labs had never been collected.

An interview was conducted on 6/4/2024 at 4:07 pm with PA #2. PA #2 reported she was notified by Nurse #6 on 12/24/2023 that Resident #196 was confused and had a cough. PA #2 reported she ordered laboratory testing and a chest x-ray. PA #2 stated she was never called about the results of the laboratory testing. PA #2 reported she was not on-call 12/25/2023, and that the on-call provider that day should have been notified.

An interview was conducted on 6/4/2024 at 8:36 pm with Nurse #7. Nurse #7 stated she worked on 12/25/2023 on night shift (7:00 pm to 7:00 am). Nurse #7 reported she drew blood at night if it was ordered but was not able to recall Resident #196 having orders for labs.

An interview was conducted on 6/7/2024 at 8:27 am with the DON. The DON stated abnormal radiology results were faxed to the facility. The DON stated Nurses checked the fax machine routinely for results and were to notify the on-call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 580	Continued From page 23 provider of any results. The DON reported laboratory tests were to be drawn and sent out. She stated the facility utilized an outside phlebotomist, but that Nurses could draw labs and use the courier until a certain time. The DON stated after the courier hours were over, if the resident had labs that needed to be drawn immediately, they would need to be sent to the hospital. The DON stated if the labs were not emergent, the phlebotomist would draw them the next morning. The DON was not aware Resident #196's labs had not been collected by Nurse #6 and that the provider was not made aware the labs had not been collected. The DON verified Resident #196's labs had never been collected and stated the on-call provider should have been notified of new laboratory results or the inability to obtain laboratory results. The DON verbalized nursing staff should have looked out for laboratory results and questioned why they were not back. An interview was conducted on 6/7/2024 at 3:20 pm with the Administrator. The Administrator stated he was not familiar with Resident #196 because he was employed at the facility at that time. The Administrator agreed that the on-call provider should have been notified with any laboratory results or the inability to obtain laboratory testing.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 600	Continued From page 24 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff, Physician Assistant (PA), and Medical Director (MD) interviews the facility failed to protect a Resident's right to be free from neglect by failing to comprehensively assess a resident prior to moving the resident off of the floor following a fall with injury, seek immediate medical treatment or hospitalization to provide the necessary care and services to the resident, and provide effective pain management. On 5/27/24 Resident #40 sustained a fall with injury and a comprehensive assessment was not completed prior to transferring the resident to bed. The resident's left leg was observed internally rotated and shorter than the right leg. Nurse #3 immediately summoned Emergency Medical Services (EMS) but after review of his chart and speaking to the Director of Nursing (DON), she was instructed to cancel EMS because Resident #40 had an advance directive that indicated "Do Not Hospitalize" unless his comfort needs could not be met at the facility. The resident was medicated with a one-time dose of Ibuprofen (pain medication, decreases inflammation) 600 milligrams (mg) in addition to the resident's routine order for oxycodone-acetaminophen 5-325 mg (narcotic pain medication) every 6	F 600	The facility neglected to thoroughly assess resident #40 on 5/27/24 at 10:40 pm after he fell from his wheelchair to the floor on his left side face down. The facility neglected to ensure Resident #40 immediately received the necessary care and services from a higher level of care after sustaining an obvious injury status post fall, effective pain management strategies identified through his assessment, and neglecting to implement identified services according to Resident #40's MOST form. By 7/5/24, the Director of Nursing will submit an initial and final investigation of the identified facility event to the State Survey Agency. Resident #40 still resides in the facility and continues to participate in his Plan of Care receiving all necessary care and services. Resident #40 went to a follow up orthopedics appointment on 6/14/2024 with no new orders. Resident #40 is currently on an increased frequency of Oxycodone 5/325 mg PO Q4 hours.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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F 600	Continued From page 25 hours. This was not effective to manage the resident's pain as evidenced pain scale ratings of an 8 out of 10 (with 10 being the worst pain possible) and non-verbal signs of pain that included crying, moaning, guarding (protecting/holding) his left leg, grimacing, and unable to be consoled by staff. An x-ray was performed on 5/28/2024 which revealed Resident #40 had sustained an acute fracture of the proximal left femur (thigh bone). Resident #40 was transferred to the hospital on 5/28/2024 where he was admitted for further evaluation and pain management. This deficient practice occurred for 1 of 3 residents reviewed for neglect (Resident #40). Immediate jeopardy began on 5/27/2024 when staff neglected to provide the necessary care and services to Resident #40 following a fall with injury. Immediate jeopardy was removed on 06/12/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: This tag is cross-referenced to: F684: Based on record review, and Resident, staff, Physician Assistant (PA), and Medical Director (MD) interviews the facility failed to perform a comprehensive assessment including vital signs before moving a resident off the floor after a fall with injury and failed to seek	F 600	Resident #40□s pain is assessed prior to scheduled routine administration, in addition to his routine pain assessment every shift identifying nonverbal pain including facial grimacing, moaning, and crying. On 6/7/24, the Chief Nursing Officer and Director of Nursing reviewed Resident #40□s medical records documentation revealing he□s receiving all necessary care and services. All current residents have the potential to be affected by this deficient practice. On 6/7/24, the Chief Nursing Officer and Director of Nursing reviewed risk management events of falls with obvious injuries within the last 30 days, as well as alert and oriented interviewed with pain issues. No residents were identified requiring a higher level of care and/or current ineffective pain management regimens were identified. Starting 6/7/24, the Chief Nursing Officer educated the Director of Nursing on the process at the time of an event ensuring residents immediately receive a higher level of care for obvious injuries, effective pain management strategies implemented and understanding MOST forms in relation to residents□ immediate needs after an event. Education includes when the MOST form indicates comfort measures are to be implemented and the facility□s unable to manage, the resident should be provided services and care at a higher level. At no time will the DON direct the facility staff to neglect providing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 600	Continued From page 26 immediate medical treatment or higher level of care. On 5/27/2024 at 10:40 pm Nurse #1, Nurse #2, Nurse #3, Nurse Aide (NA) #1, and NA #2 responded to Resident #40's room after they heard Resident #44 yell that Resident #40 was on the floor. Resident #40 was found face down on the floor. Nurse #1 and Nurse #2 rolled Resident #40 over, transferred Resident #40 by picking him up under his arms while NA #1 held "traction" to Resident #40's left leg. When Resident #40 was placed back in bed, Nurse #3 assessed Resident #40 and obtained vital signs at which time she noticed Resident #40's left leg was internally rotated and shorter than the right leg. Nurse #3 immediately summoned Emergency Medical Services (EMS) but after review of his chart and speaking to the Director of Nursing (DON), she was instructed to cancel EMS because Resident #40 had an advance directive that indicated "Do Not Hospitalize" unless his comfort needs could not be met at the facility. An x-ray was performed on 5/28/2024 which revealed Resident #40 had sustained an acute fracture of the proximal left femur (thigh bone). Resident #40 was transferred to the hospital on 5/28/2024 where he was admitted for further evaluation and pain management. The deficient practice was identified for 1 of 3 residents reviewed for change of condition (Resident #40). F697: Based on observations, record review, staff, Physician Assistant (PA), and Medical Director (MD) interviews the facility failed to provide effective pain management for a resident (Resident #40) after a fall, with obvious deformity, or transfer him to the hospital for pain that could not be managed in the facility as outlined by his advanced directive. On 5/27/2024 Resident #40 was found face down on the floor beside his bed	F 600	necessary services required from a higher level of care following an obvious injury or ineffective pain management strategies be acceptable standards of practice. The Director of Nursing, along with the clinical team, will review all falls/incidents daily in the clinical meeting to determine if the event required residents to receive a higher level of care and/or the need for additional care and services. The pain assessment conducted with each event will be reviewed during the clinical meeting for immediate interventions implemented and real time effectiveness. The clinical team will also review the MOST forms to ensure facility□s compliance with resident/responsible party□s wishes. If the post assessment following pain interventions are not effective, the Director of Nursing, along with the clinical team, will notify the clinicians of its ineffectiveness and implement additional and/or alternative measures as indicated. Starting 6/7/24, The Director of Nursing/Staff Development Coordinator will in-service all facility staff (including contracted agency staff) on Neglect, including failing to provide the necessary care and services from a higher level of care and effective pain management strategies following an event with obvious injuries. The Director of Nursing/Staff Development Coordinator will educate all new hires during orientation and scheduled contracted agency nurses prior to working their shift. The Administrator and Chief Nursing Officer will ensure all facility staff (including contracted agency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 600	Continued From page 27 and was noted to have internal rotation and shortening of the left hip and leg. Resident #40 was crying, moaning, guarding (protecting/holding) his left leg, grimacing, and unable to be consoled by staff. Nurse #3 immediately summoned Emergency Medical Services (EMS) but after review of the resident's chart and speaking to the Director of Nursing (DON), she was instructed to cancel EMS because Resident #40 had an advance directed that indicated "Do Not Hospitalize" unless his comfort needs could not be met at the facility. Nurse #3 notified the provider on-call and obtained an order for a one-time dose of Ibuprofen (pain medication, decreases inflammation) to be given for pain and a left hip/pelvis x-ray. Nurse #3 administered that medication as well as oxycodone-acetaminophen 5-325 mg (pain medication) that was scheduled (for every 6 hours) at 12:00 am and Resident #40 continued to grimace in pain throughout the remainder of her shift. Nurse #3 administered the 6:00 am oxycodone-acetaminophen. Nurse #10 administered oxycodone-acetaminophen 5-325 mg tablet on 5/28/2024 at 12:19 pm, and documented a pain assessment of 8 out of 10 for Resident #40. An x-ray was performed in the facility on 5/28/2024 which revealed Resident #40 had sustained an acute fracture of the proximal left femur (thigh bone) and Resident #40 was transferred to the hospital on 5/28/2024 where he was admitted for further evaluation and pain management. The deficient practice occurred for 1 of 3 residents (Resident #40) reviewed for pain management. The Administrator was notified of Immediate Jeopardy on 6/5/2024 at 11:35 am.	F 600	staff) are educated. . The Director of Nursing will submit the findings of the daily clinical fall/incident reviews in the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 600	Continued From page 28	F 600		

The facility provided the following credible allegation of immediate jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility neglected to thoroughly assess resident #40 on 5/27/24 at 10:40 pm after he fell from his wheelchair to the floor on his left side face down. Resident #40 was discovered by his roommate who summoned assistance from staff. Nurse #1, Nurse #2, NA #1, and NA #2 lifted resident #40 under his arms and held traction to Resident #40's left leg and picked him up from the floor and placed him in the bed. Nurse #3 completely assessed Resident #40 and observed that the left leg was internally rotated and shortened. Nurse #1 described left leg as a "limp noodle."
The facility neglected to ensure Resident #40 immediately received the necessary care and services from a higher level of care after sustaining an obvious injury status post fall, effective pain management strategies identified through his assessment, and neglecting to implement identified services according to Resident #40's MOST form.

Resident #40 still resides in the facility and continues to participate in his Plan of Care receiving all necessary care and services to include a pending orthopedic follow-up appointment. Awaiting the orthopedics office to review the referral documentation and provide the facility with the appointment date. Resident #40 is currently on an increased frequency of Oxycodone 5/325 mg PO Q4 hours. Resident #40's pain is assessed prior to scheduled routine

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 600	Continued From page 29	F 600		

administration, in addition to his routine pain assessment every shift identifying nonverbal pain including facial grimacing, moaning, and crying.

On 6/7/24, the Chief Nursing Officer and Director of Nursing reviewed Resident #40's medical records documentation revealing he's receiving all necessary care and services.

All current residents have the potential to be affected by this deficient practice.

On 6/7/24, the Chief Nursing Officer and Director of Nursing reviewed risk management events of falls with obvious injuries within the last 30 days, as well as alert and oriented interviewed with pain issues. No residents were identified requiring a higher level of care and/or current ineffective pain management regimens were identified.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Starting 6/7/24, the Chief Nursing Officer educated the Director of Nursing on the process at the time of an event ensuring residents immediately receive a higher level of care for obvious injuries, effective pain management strategies implemented and understanding MOST forms in relation to residents' immediate needs after an event. Education includes when the MOST form indicates comfort measures are to be implemented and the facility's unable to manage, the resident should be provided services and care at a higher level. At no time will the DON direct the facility staff to neglect providing the necessary services required from a higher level of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 600	Continued From page 30	F 600		

care following an obvious injury or ineffective pain management strategies be acceptable standards of practice. The Director of Nursing, along with the clinical team, will review all falls/incidents daily in the clinical meeting to determine if the event required residents to receive a higher level of care and/or the need for additional care and services. The pain assessment conducted with each event will be reviewed during the clinical meeting for immediate interventions implemented and real time effectiveness. The clinical team will also review the MOST forms to ensure facility's compliance with resident/responsible party's wishes. If the post assessment following pain interventions are not effective, the Director of Nursing, along with the clinical team, will notify the clinicians of its ineffectiveness and implement additional and/or alternative measures as indicated.
Starting 6/7/24, The Director of Nursing/Staff Development Coordinator will in-service all facility staff (including contracted agency staff) on Neglect, including failing to provide the necessary care and services from a higher level of care and effective pain management strategies following an event with obvious injuries. The Director of Nursing/Staff Development Coordinator will educate all new hires during orientation and scheduled contracted agency nurses prior to working their shift. The Administrator and Chief Nursing Officer will ensure all facility staff (including contracted agency staff) are educated.

Effective 6/10/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 600	Continued From page 31 A validation of immediate jeopardy removal was conducted on 06/13/24. The inital audit of residents records and pain interviews with alert and oriented residents were reviewed with no issues noted. Staff interviews across all departments were able to verbalize that they had recieved the education on neglect, how to respond if they were aware of neglect, and who to immediately report it to. The staff were able to verbalize examples of neglect and ways to identify neglect. Nursing staff were able to verbalize the need to review residents MOST forms after falls with injury and the need to contact the residents responsible party if the resident required a higher level of care. Nursing staff were also able to verbalize the pain assessment protocol and who to report any changes in pain or ineffectiveness of currently scheduled pain medication. The immediate jeopardy removal date of 06/12/24 was validated.	F 600		
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 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	F 609		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 609	Continued From page 32 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 reviews and staff interviews, the facility failed to submit a 5-Day Investigation Report within the required timeframe to the State Agency for 1 of 1 resident reviewed for misappropriation of property (Resident # 247). The findings include: Review of the facility's Abuse Policy titled Abuse, Neglect, and Exploitation, dated 10/22/2023 revealed in part, "all alleged violations involving misappropriation of resident property will be reported immediately to the Administrator who will ensure the initial report and the 5-day investigation report were received as required by the state agency". A review of the Initial Allegation Report completed by the Director of Nursing (DON) revealed Resident #247 reported his personal bank card was missing and had been used without Resident #247's consent. The Initial Allegation Report was	F 609	Resident #247 5-day investigation report was refaxed to the state on 6/27/24 by the Director of Nursing with faxed confirmation as received. The facility 5 day investigations in the last 60 days were reviewed by the Chief Nursing Officer on 6/27/24 to ensure 5 day investigations have been faxed to the state and with fax confirmations. No concerns were noted. The Director of Nursing and the Administrator were educated by the Chief Nursing Officer on 6/27/24 on ensuring that 5-day investigations are being faxed to the state within 5 days and the facility has confirmation that the State received that 5 day investigation. The Administrator/Director of Nursing will complete audits of the 5-day investigations weekly x 4 weeks and monthly x 2 months to ensure that 5 day investigations have been faxed to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 609	Continued From page 33 faxed to the State Agency on 12/01/2023 at 11:01 AM. The 5-day Investigation Report was not received by the State Agency as of 06/06/2024 at 10:47 AM. On 06/04/2023 at 2:15 PM an interview was conducted with the DON. The DON stated the Social Services Director notified her on 12/01/2023 at 9:00 AM that Resident #247 was missing his credit card. The DON stated that she notified the police department on 12/01/2023 at 10:00 AM. The DON explained that she completed the 24-hour report and faxed the document to the state agency on 12/01/2023 around 11:00 AM. The DON further explained that an internal investigation was initiated, and a 5-day investigation report was completed. The DON stated that she thought she had faxed the 5-day report to the State Office when she completed the report on 01/08/2024 but she could not locate the 5-day report fax confirmation. The DON further stated she was aware of the requirement to submit the 5-day investigation report to the State Office. An interview was conducted with the Administrator on 06/04/2023 at 3:00 PM. The Administrator stated that he had only been in his position since March 2024 and was not in the facility at the time of the incident. The Administrator revealed he was aware of the requirement to submit the 5-day investigation report to the State Office.	F 609	state within 5 days and the facility has the fax confirmation. The Administrator will report the findings of the audits to the monthly Quality Assurance Improvement Performance committee to ensure continued compliance and/or revision.	
F 626 SS=G	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2)	F 626		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 626	Continued From page 34 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Resident Responsible Party (RP) interviews the facility	F 626	The facility failed to readmit Resident #346 after being hospitalized following MD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 626	Continued From page 35 failed to permit a resident (Resident #346) who required skill nursing services to return to the facility after being sent to the Emergency Department (ED) for evaluation on 07/08/2023 after he cut himself with a soda can. On 7/11/2023, Hospital Social Worker #1 contacted the Admissions Coordinator at the facility and informed her that Resident #346 had been cleared by in-house psychiatric services, no longer required acute care or in-patient psychiatric services, and his hospital-issued involuntary commitment (IVC) paperwork had been reversed. The facility did not accept Resident #346 for readmission. The hospital sent Resident #346's skilled nursing referrals to 50 other skilled nursing facilities and was unable to place Resident #346. Resident #346 remained in the Emergency Department until he was discharged home on 7/19/2023 with his elderly parents who were not physically able to care for him. Emergency Department documentation revealed Resident #346 had acquired a deep tissue injury to his left heel at the skilled nursing facility, prior to arrival at the Emergency Department on 7/8/2023 that required wound care. The deficient practice was identified for 1 of 3 residents reviewed for discharge (Resident #346). Resident #346 was transferred to the Emergency Department on 07/08/23 and was treated and stabilized on 07/11/23. Resident #346 remained in the Emergency Department from 07/11/23 through 07/19/23 while awaiting discharge plans. The reasonable person would be anxious, scared, and fearful of being the Emergency Department for such an extended period of time. The findings included:	F 626	orders for behavioral management on 7/8/23. On 6/10/24, the Admissions Director reached out to Forsyth Medical Center to inform the case managers when Resident #346□s referral is ready, the Admissions Director will review the referral documentation and extend a bed offer if the facility□s able to meet the resident□s current needs. The case manager reported that Resident #346 plans to return home with family when discharged. On 6/7/24, the Director of Nursing and Administrator reviewed the discharge to the hospital report for the last 30 days. No current residents are hospitalized who are at risk as a result of this deficient practice. On 6/7/24, the Director of Nursing and Administrator reviewed residents hospitalized within the past 30 days to ensure any resident who was ready to return to the facility, and still needed the level of care offered by the facility was not denied readmission consistent with federal regulation. No inappropriate denials of readmission to the facility or other issues were identified from review. Of the seven residents discharged to the hospital, four residents were readmitted to the facility, one resident was discharged to the Veterans Administration facility per family□s choice, one resident expired, and one resident discharged home. On 6/10/24, the Administrator educated the Director of Nursing and Admission□s Director on the readmission process. The process for readmission includes the	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 626	Continued From page 36 A review of an initial referral dated 6/28/2023 for Resident #346 revealed he had been hospitalized since 6/25/2023 for aggression, depressed mood, and suicidal ideation. Documentation revealed Resident #346 had been stabilized in the Emergency Department and was not a candidate for inpatient psychiatric services due to his acute medical needs and total care needs that required management outside the inpatient psychiatric setting. On the cover sheet of the initial referral was a handwritten note that read; "patient had behaviors at arrival due to drug resistant Urinary Tract Infection (UTI), he has gotten on the right antibiotics and has had no behaviors since." Resident #346 was admitted to the facility on 6/29/2023 with diagnoses which included bipolar, anxiety, post-traumatic stress disorder, and major depressive disorder. A review of an admission Minimum Data Set (MDS) dated 7/6/2023 revealed Resident #346 was cognitively intact and was coded as feeling down, depressed, and hopeless, had trouble falling asleep, felt tired/little energy, poor appetite, felt bad about self, had trouble concentrating, and had thoughts he would be better off dead. Resident #346 was coded as having physical behavioral symptoms directed towards others (1 to 3 days), verbal behavior symptoms directed towards others (1 to 3 days), and other behavioral symptoms not directed towards others (1 to 3 days). The behaviors were coded as putting Resident #346 at significant risk for physical illness or injury, interfering with Resident #346's care, and interfering with Resident #346's participation in activities and social interactions. Resident #346 was coded as placing others at risk of physical injury. Resident #346 was coded	F 626	facility readmitting residents once the hospital communicates, they□re stable for discharge. Stable residents cleared by the hospital staff at the time of discharge will be readmitted to the facility per federal regulations residents□ rights to return to the facility after a hospital transfer. At no time will a resident□s readmission be denied by the facility. On 6/10/24, the Administrator educated the Director of Nursing and Admission□s Director on the federal regulations, to include when residents are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident□s return is generally expected. Residents who are sent emergently to an acute care setting, such as a hospital, must be permitted to return to the facility. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident□s status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets the criteria identified. Additionally, the resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that the failure to transfer or discharge would pose. On 6/7/24, the Chief Nursing Officer in-serviced the Director of Nursing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 626	Continued From page 37 as requiring maximum assistance for toileting (had an indwelling catheter and was always incontinent of bowel), bathing/showering, substantial/maximal assistance with lower body dressing and putting on/taking off footwear, partial/moderate assistance with upper body dressing, supervision/touching assistance with oral hygiene, and was independent for eating. Resident #346 was coded as requiring substantial/maximum assistance with rolling left to right and retuning to lying on back in bed, from lying to sitting and was dependent for chair/bed-to-chair transfers. Resident #346 was coded as using a wheelchair and was not ambulatory. Resident #346 was not coded as having a pressure ulcer or injury. A review of a care plan dated 7/6/2023 revealed Resident #346 was admitted short term, had verbally aggressive behaviors towards staff, had behaviors which included throwing objects, playing loud music, fabricating stories, physically aggression towards staff, and Resident #346 had not been care planned for a history of suicidal ideation. A review of a nursing note dated 7/7/2023 at 12:28 pm written by the DON revealed Resident #346 threw his lunch tray in the hall and refused to take his medications. Staff received orders to send Resident #346 to the Emergency Department due to behaviors and refusal to take medications. A review of a nursing note dated 7/7/2023 at 8:30 pm written by the DON revealed PA #1 was in the facility when Resident #346 struck a staff member in the abdomen. The Social Worker (SW) and nursing staff went to the Magistrate's	F 626	Admissions Director and Social Worker on the readmission policy and procedure to include a residents' right to return from a hospitalization if the facility remains able to provide care needed by the resident, once the facility is notified the resident is stable and ready to return to the facility. Starting 6/7/24 where a resident has been sent to the hospital for behavioral reasons, the DON/Administrator/Chief Nursing Officer will review and discuss the residents' status once it is communicated the resident is stable to return. The Clinical team to include the Director of Nursing, Unit Manager, social services, Administrator, and the Medical Director will review what interventions were done by the hospital physicians that are clearing the resident to ensure hospital interventions are being updated at the facility, if previous interventions were ineffective. By 7/16/24, the Chief Nursing Officer will educate the Director of Nursing, Unit Manager, social services, Administrator, and the Medical Director on the readmission polices and procedures. New hire members of the clinical team will be educated in orientation by the Chief Nursing Officer, Administrator, and/or the Director of Nursing. Beginning 6/7/24, the Director of Nursing and Admissions Director will review weekly x 12 weeks the status of any resident transferred to the hospital for	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 626	Continued From page 38 office where they were denied involuntary commitment (IVC) papers and instructed staff to call law enforcement to report Resident #346 hitting a staff member. A review of a nursing note dated 7/7/2023 at 8:31 pm revealed Resident #346 was found to be in the courtyard where he had thrown garbage and taken the facility's fire extinguisher and sprayed it all over the ground. Resident #346 had refused to take his medications and yelled at a Nurse Aide (NA). A review of a nursing note dated 7/8/2023 at 9:29 pm written by Nurse #8 revealed Resident #346 rang his call bell. When the staff arrived at Resident #346's room, he had cut himself with a soda can and cut himself on the top area of his right leg. Resident #346 then stated, "I am suicidal, and I want to go to the hospital." An interview was conducted on 6/6/2024 at 3:55 pm with Nurse #8. Nurse #8 stated she worked on 7/8/2024 during night shift (7:00 pm to 7:00 am) and was assigned Resident #346. Nurse #8 stated a staff member had come and gotten her to check on Resident #346. Nurse #6 stated when she arrived at Resident #346's room, she observed blood on his upper thigh and had been cutting himself with a soda can. Nurse #8 reported she removed the can from Resident #346's room, had a staff member stay with him and contacted the Director of Nursing (DON). Nurse #8 stated the DON told her to contact law enforcement and Emergency Medical Services (EMS) to have him sent to the Emergency Department. Nurse #8 reported she given report to EMS, notified Resident #346's RP and transferred him to the hospital.	F 626	behavior management. When the hospital communicates the resident is ready for discharge, the clinical team will review hospital notes, talk with the hospital staff to ensure the resident is stable, no longer requiring acute care and the facility will readmit the resident. The Director of Nursing will report the weekly findings to the Quality Assurance Performance Improvement Plan (QAPI) committee to ensure continual compliance and for review and/or revision.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 626	Continued From page 39	F 626		

A review of the Emergency Department records revealed the following:

An Emergency Department note dated 7/8/2023 at 11:46 pm revealed Resident #346 was presented to the Emergency Department via EMS for suicidal ideation.

An Emergency Department note dated 7/11/2023 at 10:30 pm revealed Resident #346 had been seen by mental health staff and was started on a mood stabilizer.

An Emergency Department note dated 7/12/2023 at 10:59 am revealed Resident #346 had rested comfortably overnight without any issues. Resident #346 was found to have a Urinary Tract Infection (UTI) and was started on antibiotics. The medical team discussed Resident #346 was not homicidal or suicidal and continued to seek placement in a skilled nursing facility.

A review of the Emergency Department record dated 7/19/2023 at 1:02 pm revealed Resident #346 was discharged home with his RP.

An interview was conducted on 6/7/2024 at 11:49 am with Hospital Social Worker #1. Hospital Social Worker #1 stated she contacted the facility's Admissions Coordinator on 7/11/2023 and was told that the facility would not accept Resident #346 back until he had received in-patient psychiatric services. Hospital Social Worker #1 informed the Admissions Coordinator that Resident #346 was cleared by in-house psychiatric services, no longer required acute care or in-patient psychiatric services, and his hospital-issued IVC had been reversed and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 626	Continued From page 40	F 626		

Admissions Coordinator stated the facility would not take Resident #346 back. The Hospital Social Worker stated she had sent referrals to over 50 skilled nursing facilities and was never able to place Resident #346. The Hospital Social Worker stated Resident #346 was sent home to be cared for by his parents on 7/19/2023.

An interview was conducted on 6/6/2024 at 4:54 pm with the Admissions Coordinator. The Admissions Coordinator stated she was employed at the facility on 7/11/2023 and no longer worked at the facility. The Admissions Coordinator stated she remembered Resident #346's RP really wanted him to reside long term at the facility when he was admitted. The Admissions Coordinator stated the facility had sent Resident #346 to the hospital for psychiatric reasons and was told by the DON not to accept Resident #346 back to the facility because he needed to be in a psychiatric facility. The Admissions Coordinator was unable to recall any communication with the hospital after Resident #346 was transferred for evaluation.

A telephone interview was conducted on 6/6/2023 at 11:17 am with Resident #346's RP. The RP stated Resident #346 was sent to the Emergency Department on 07/08/23 because the facility staff had stated he was suicidal. The RP reported that while Resident #346 was being stabilized in the hospital he went to the facility to speak with the DON about Resident #346 returning after discharge and was told by the DON, they would not take him back. The RP stated the hospital never could find Resident #346 anywhere to go, and that he (the RP) would have to take him home. The RP stated he was the primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 626	Continued From page 41	F 626		

caregiver for Resident #346 after discharge and struggled to take care of Resident #346 and his elderly spouse who had end-stage Parkinson's disease, while he continued to work fulltime.

An interview was conducted on 6/6/2024 at 9:22 am with facility Social Worker (SW) #1. SW #1 reported she remembered Resident #346 and his transfer to the hospital. SW #1 reported she had not called the hospital, sent a transfer/discharge notice, or bed hold documentation to the family because the hospital was his "safe discharge." SW #1 was unable to recall if the DON had informed her, they would not accept Resident #346 back to the facility.

An interview was conducted on 6/6/2024 at 9:28 am with the DON. The DON reported Resident #346 had been sent to the hospital for suicidal ideation on 7/8/2023. The DON stated prior to his transfer to the ED he had been aggressive towards the staff and had hit one of the nurses. The DON reported the facility was not able to manage his behaviors. The DON reported she discharged him to the hospital with the intent of not taking him back to the facility because she was worried about the safety of the residents and staff. The DON stated the Admissions Director was aware that he had a history of behaviors, aggression, and suicidal ideation, but had not informed her until right before he arrived at the facility on 06/29/23. The DON stated she never would have accepted Resident #346 if she had known that prior to his admission. The DON reported she never followed up with the hospital once he was transferred and stated the RP had come to the facility and asked multiple times for Resident #346 to be taken back and she informed the RP she would not accept him back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 626	Continued From page 42 to the facility. An interview was conducted on 6/6/2024 at 6:00 pm with the Previous Administrator. The Previous Administrator reported he was employed at the facility on 7/8/2023, but was not able to recall Resident #346, his transfer, or discharge.	F 626		
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 record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for anticoagulants (blood thinners) and Pre-Admission Screening and Resident Review (PASRR) information for 3 of 3 residents reviewed for accuracy of assessments (Residents #68, #196, and #346). The findings included: 1. Resident #68 was admitted to the facility on 2/28/2023 with diagnoses which included Major Depressive Disorder, anxiety, bipolar, and borderline personality disorder. A review of the annual MDS dated 3/5/2024 revealed Resident #68 was moderately cognitively impaired and was not coded as having a Level II Pre-Admission Screening and Resident Review (PASRR). A review of a care plan dated 3/5/2024 revealed Resident #68 had a Level II PASRR	F 641	Resident #68 annual Minimum Data Set (MDS) dated 3/5/2024 was modified to include the Level 2 Pre-Admission Screening and Resident Review (PASRR) by the MDS coordinator on 6/12/2024. Resident #196's discharge MDS dated 12/26/23 was updated to include that the resident received anticoagulant medication by the MDS coordinator on 6/12/2024. Resident #346 admission was modified to include Level 2 PASRR by the MDS coordinator on 6/12/2024. Current residents that receive anticoagulant medications and residents with level 2 PASRR are at risk for this deficit practice. On 6/28/24, the Reimbursement Clinical Specialist audited current residents receiving anticoagulant. 1 MDS was identified as needing modifications. On 6/28/24, the Reimbursement Clinical	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 641	Continued From page 43 determination due to serious mental illness. An interview was conducted on 6/6/2024 at 9:00 am with the MDS Nurse. The MDS Nurse reported when a resident was admitted to the facility, Admissions and the Social Worker (SW) would verify if the resident had a Level II PASRR. The MDS Nurse stated Resident #68 had a Level II PASRR and verified the annual MDS dated 3/5/2024 was inaccurate. The MDS Nurse stated someone else had completed the annual MDS assessment and she was unsure why it was inaccurately documented. An interview was conducted on 6/7/2024 at 8:27 am with the Director of Nursing (DON). The DON stated the MDS Nurse was responsible for accurately completing the MDS assessments. The DON stated she was not familiar enough with MDS to know if a Level II PASRR was required to be coded and would have to refer to the MDS Nurse. An interview was conducted on 6/7/2024 at 3:19 pm with the Administrator and indicated they expected the MDS to be coded correctly. 2. Resident #196 was admitted to the facility on 12/18/2023 with diagnoses which included pulmonary embolisms (a condition in where an artery in the lung is blocked by a clot). A review of Resident #196's medical record revealed a physician's orders dated 12/18/2023 for apixaban (anticoagulation medication used to prevent blood clots) 5 milligrams (mg) 2 tablets twice a day for anticoagulation for 7 days. A review of Resident #196's Medication	F 641	Specialist audited current residents with Level 2 PASRRs, and residents were reviewed. 6 MDS assessments were identified as needing notifications. On 6/28/24, the Reimbursement Clinical Specialist educated MDS nurse to include the prn MDS nurse related to ensuring that the Minimum Data Set (MDS) assessments are being coded accurately. The Administrator/Reimbursement Clinical Specialist will ensure newly hired MDS nurses and prn MDS nurses will receive education during facility orientation and will not be allowed to work until the education is completed. The Reimbursement Clinical Specialist/Director of Nursing/Staff Development Coordinator will complete audits of the current residents that receive anticoagulants and residents with Level 2 PASRRs weekly x 4 weeks and monthly x 2 months to ensure ongoing compliance. The Reimbursement Clinical Specialist/Director of Nursing/Staff Development Coordinator/Unit Manager will report the findings monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 641	Continued From page 44	F 641		

Administration Record (MAR) indicated Resident #196 had received apixaban twice a day from 12/19/2023 through 12/25/2023.

A review of the care plan dated 12/25/2024 for Resident #196 did not include the use of anticoagulants.

A review of Resident #196's discharge MDS dated 12/26/2023 did not indicate anticoagulant medication had been received.

An interview was conducted 6/6/2024 at 9:05 am with the MDS Nurse. The MDS Nurse reported if a resident was prescribed apixaban then use of anticoagulants should be coded. The MDS Nurse confirmed that Resident #196 was prescribed apixaban and should have been coded for anticoagulants. The MDS Nurse stated she had not completed the discharge assessment and was not sure why it was not coded correctly.

An interview was conducted on 6/7/2024 at 8:27 am with the Director of Nursing (DON). The DON stated the MDS Nurse was responsible for accurately completing the MDS assessments. The DON stated she was not familiar enough with MDS to know if anticoagulants were required to be coded and would have to refer to the MDS Nurse. The DON agreed that apixaban was classified as an anticoagulant.

An interview was conducted on 6/7/2024 at 3:19 pm with the Administrator and indicated they expected the MDS to be coded correctly.

3. Resident #346 was admitted to the facility on 6/29/2023 with diagnoses which included bipolar, anxiety, post-traumatic stress disorder, and major

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 641	Continued From page 45	F 641		

depressive disorder.

A review of an admission MDS dated 7/6/2023 revealed Resident #346 was cognitively intact with no behaviors and was not coded as having a Level II Pre-Admission Screening and Resident Review (PASRR).

A review of a care plan dated 7/6/2023 revealed Resident #346 did not have a Level II PASRR determination.

A review of the PASRR confirmation documentation revealed Resident #346 had a Level II PASRR with an expiration date of 9/5/2023.

A review of the medical record demographic section revealed Resident #346 had a Level I PASRR determination.

An interview was conducted on 6/6/2024 at 9:00 am with the MDS Nurse. The MDS Nurse reported when a resident was admitted to the facility, Admissions and the Social Worker (SW) would verify if the resident had a Level II PASRR. The MDS Nurse stated Resident #346 had a Level II PASRR determination. The MDS Nurse stated in the demographics, Resident #346 was indicated as having a Level I PASRR. The MDS Nurse stated she had not completed that assessment and assumed the Nurse who completed the assessment probably referred to the demographics and had not looked at the PASRR documentation that was scanned into the chart. The MDS Nurse reported Resident #346 should have been coded with a Level II PASRR and that it was an error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 641	Continued From page 46 An interview was conducted on 6/7/2024 at 8:27 am with the Director of Nursing (DON). The DON stated the MDS Nurse was responsible for accurately completing the MDS assessments. The DON stated she was not familiar enough with MDS to know if a Level II PASRR was required to be coded and would have to refer to the MDS Nurse. An interview was conducted on 6/7/2024 at 3:19 pm with the Administrator and indicated they expected the MDS to be coded correctly.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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F 656	Continued From page 47 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and implement a person-centered care plan for a resident (Resident #346) with a history of suicidal ideation for 1 of 2 residents reviewed for development and implementation of a comprehensive care plan. The findings included: Resident #346 was admitted to the facility on 6/29/2023 with diagnoses which included bipolar, anxiety, post-traumatic stress disorder, and major depressive disorder. A review of a facility referral dated 6/28/2023 revealed Resident #346 would be discharged	F 656	Resident #346 was sent to the emergency room on 7/8/23 and did not return to the facility. Current residents with suicidal ideation are at risk for this deficit practice. By 7/16/24, the Director of Nursing will review current residents' care plan that have a history and/or current suicidal ideation and update any identified care plan as needed. Starting 6/27/24, the Director of Nursing will educate social services and the licensed nurses to ensure a comprehensive plan of care is developed and implemented for residents with a history and/or current suicidal ideations.	

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F 656	Continued From page 48 from the hospital after being admitted with aggression, depressed mood, and suicidal ideation. A review of an admission MDS dated 7/6/2023 revealed Resident #346 was cognitively intact and was coded as feeling down, depressed, and hopeless, had trouble falling asleep, felt tired/little energy, poor appetite, felt bad about self, had trouble concentrating, and had thoughts he would be better off dead. Resident #346 was coded as having physical behavioral symptoms directed towards others (1 to 3 days), verbal behavior symptoms directed towards others (1 to 3 days), and other behavioral symptoms not directed towards others (1 to 3 days). The behaviors were coded as putting Resident #346 at significant risk for physical illness or injury, interfering with Resident #346's care, and interfering with Resident #346's participation in activities and social interactions. Resident #346 was coded as placing others at risk of physical injury. A review of a care plan dated 7/6/2023 revealed Resident #346 had not been care planned for a history of suicidal ideation. A review of a nursing note dated 7/8/2023 at 9:29 pm written by Nurse #8 revealed Resident #346 rang his call bell. When the staff arrived at Resident #346's room, he had cut himself with a soda can and cut himself on the top area of his right leg. Resident #346 then stated, "I am suicidal, and I want to go to the hospital." Resident #346 was sent to the hospital for suicidal ideation and had not returned to the facility. An interview was conducted on 6/6/2024 at 9:00	F 656	New hires, agency, and prn social service and licensed nurses will not be allowed to work until the education is completed. Social Services will complete audits weekly x 4 weeks and monthly x 2 months of comprehensive care plans to ensure residents with suicidal ideation care plans have been developed and implemented. Social Service will submit their findings to the Quality Assurance Implementation Plan (QAPI) committee for review and revision to ensure continual compliance.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 656	Continued From page 49 am with the MDS Nurse. The MDS Nurse reported SW went through hospital documentation on admission and would identify if a resident had a history of suicidal ideation. The MDS Nurse reported that suicidal ideation should be care planned. The MDS Nurse was not sure why Resident #346 had not been care planned for suicidal ideation and agreed that he should have been. An interview was conducted on 6/6/2024 at 12:09 pm with SW #1. SW #1 stated she reviewed hospital documentation when a resident was admitted. SW #1 reported she had not noticed Resident #346 had been hospitalized for suicidal ideation. SW #1 verified Resident #346 had not been care planned for suicidal ideation and agreed that he should have been. An interview was conducted on 6/7/2024 at 8:45 am with the Director of Nursing (DON). The DON stated if a resident had a history of suicidal ideation, it should be care planned. The DON reported that section of the care plan should be completed by the MDS Nurse or SW. The DON was not aware Resident #346 had not been care planned for suicidal ideation and agreed that he should have been. An interview was conducted on 6/7/2024 at 3:27 pm with the Administrator. The Administrator stated if a resident was admitted to the facility after being hospitalized for suicidal ideation, the resident should have been care planned for suicidal ideation. The Administrator agreed Resident #346 should have been care planned for suicidal ideation.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 657	Continued From page 50 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 reviews and staff and Resident interviews the facility failed to update a care plan in the area of smoking for 1 of 1 resident reviewed for safe smoking (Resident #62). The finding included: Resident #62 was admitted to the facility on	F 657	Resident #62 smoking care plan was updated on 6/7/24 by SW #1. Residents that smoke are at risk for this deficient practice. On 6/11/24, social services completed an audit of the current residents that smoke. 1 smoking care plan was updated. On 6/28/24, the Chief Nursing Officer	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 657	Continued From page 51 01/27/23 with diagnoses that included cerebral vascular accident and dementia. A review of Resident #62's medical record revealed the last safe smoking screening dated 03/31/23 indicated the Resident was able to smoke independently. The screen was completed by Social Worker (SW) #1. A review of Resident #62's care plan revised on 02/03/24 revealed the Resident was a supervised smoker with the goal that he would not smoke without supervision through the next review. The interventions included both 1) the Resident required supervision while smoking and 2) the Resident can smoke unsupervised. A review of Resident #62's annual Minimum Data Set (MDS) assessment dated 02/04/24 revealed the Resident's cognition was moderately impaired and he used tobacco. During an interview with Social Worker (SW) #1 on 06/07/24 at 9:11 AM, the SW explained that she was the one responsible for writing Resident #62's smoking care plan and that the Resident was a safe smoker who could smoke unsupervised. The SW was asked to review Resident #62's smoking care plan that stated the Resident was both a supervised and unsupervised smoker and the SW acknowledged the discrepancy in the care plan and stated she had made a mistake. The SW stated Resident #62 was able to smoke unsupervised. An interview was conducted with the Director of Nursing (DON) on 06/07/24 at 10:03 AM. The DON explained that social services wrote the smoking care plans and she expected the care	F 657	educated social services on ensuring resident smoking care plans are being updated as needed. New hire social services will be required to complete the education in orientation and will not be allowed to work without completing the education. Social Services will complete audits of residents' smoking care plans weekly x 4 weeks and monthly x 2 months. Social Services will submit the findings in the Quality Assurance Improvement Plan (QAPI) committee meeting for continual compliance for review and/or revision.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 657	Continued From page 52 plan to accurately reflect the Resident's ability to smoke unsupervised.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide nail care for a dependent resident (Resident #40) and failed to provide a haircut for a dependent resident (Resident #78) for 2 of 10 dependent residents reviewed for activities of daily living (ADL). The findings included: 1. Resident #40 was admitted to the facility on 5/19/2018. Resident #40 had diagnoses which include dislocation (ball joint comes out of socket) of the left hip and was documented as deaf and mute. A quarterly Minimum Data Set (MDS) dated 5/8/2024 revealed Resident #40 was severely cognitively impaired. Resident #40 was documented as requiring setup or clean-up assistance for eating and was dependent for personal hygiene. A review of the care plan dated 5/8/2024 revealed Resident #40 required partial to moderate assistance with hygiene. An observation was conducted on 6/3/2024 at	F 677	F677 Resident #4 nails were cleaned and cut by the Nurse Aide on 6/10/24. The facility on 6/7/24 offered to transport and pay for Resident #78 a haircut. Resident #78 declined. On 6/28/24, social services offered to transport and pay for resident #78 a haircut, and she accepted the offer. On 6/27/24 a new hair stylist was hired for the facility by the Administrator. Current residents are at risk for this deficient practice. On 6/28/24, the Director of Nursing completed an audit of the current residents□ nails. 32 residents□ nails were cut and/or cleaned, and 5 residents refused. By 7/16/24, Social Services will complete an audit of residents who require haircuts. Starting 6/27/24, The Director of Nursing/ Unit Manager will educate the nursing staff to include certified nursing assistants, certified medication aides, licensed nurses, agency, prn, and new hires related to ensuring resident nails are cleaned and/or trimmed. Resident	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 677	Continued From page 53 11:01 am. Resident #40 was observed with quarter-inch long fingernails, on all ten fingernails on both the right and left hands, with a brown substance underneath. An observation was conducted on 6/4/2024 at 8:50 am. Resident #40 was observed with quarter-inch long fingernails, on all ten fingernails on both the right and left hands, with a brown substance underneath. An observation was conducted on 6/4/2024 at 1:16 pm. Resident #40 was observed with quarter-inch long fingernails, on all ten fingernails on both the right and left hands, with a brown substance underneath. An observation was conducted on 6/5/2024 at 2:26 pm. Resident #40 was observed with quarter-inch long fingernails, on all ten fingernails on both the right and left hands, with a brown substance underneath. An interview was conducted on 6/5/2024 at 2:48 pm with Nurse Aide (NA) #6. NA #6 reported she was assigned to care for Resident #40 that day, 6/5/2024. NA #6 reported nail care is performed anytime that a resident is noted to have long or dirty nails. NA #6 had verbalized she had been trained on how to cut and clean nails. NA #6 was asked to observe Resident #40's fingernails and agreed that they were long, dirty, and needed to be cut and cleaned. NA #6 stated she would cut and clean Resident #40's fingernails. A review of a shower sheet dated 6/6/2024 revealed Resident #40 had his nails cleaned and trimmed by NA #8.	F 677	refusals will be reported to the charge nurse for follow up and documented in the medical record. Staff will not be allowed to work after 7/16/24 until the education is completed. New hire staff will be educated in orientation. New agency staff will be updated in the new agency orientation binder. Starting 6/27/24, the Director of Nursing /Unit Manager will educate nursing staff to include licensed nurses, certified medication aides and certified nursing assistants, social services, and business office staff on placing identified resident names on the beauty shop list at the receptionist desk. The Director of Nursing will complete audit weekly x4 weeks and monthly x 2 months of residents that need nail care and/or hair trimmed. The Director of Nursing will submit the findings to the Quality Assurance Improvement Performance (QAPI) committee for review/revision to ensure continual compliance.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 677	Continued From page 54	F 677		

An interview with NA #8 was attempted on 6/6/2024, which was unsuccessful.

An observation was conducted on 6/6/2024 at 9:15 am. Resident #40 was observed with quarter-inch long fingernails, on all ten fingernails on both the right and left hands, with a brown substance underneath. Resident #40 was observed picking up bread with his left hand and putting the bread in his mouth.

A follow-up interview with NA #6 was attempted on 6/6/2024, which was unsuccessful.

An interview was conducted on 6/6/2024 at 12:26 pm with the Unit Manager (UM). The UM reported she had educated NA's regarding nail care, which included cutting and cleaning fingernails. The UM stated she made daily rounds on long-term care residents and reminded NAs to complete ADL tasks. The UM reported she monitored nail care and if she noticed long and/or dirty fingernails on a resident, she would bring it to the attention of their NA. The UM had not noticed Resident #40 had long, dirty fingernails.

An interview was conducted on 6/7/2024 at 9:10 am with NA #7. NA #7 reported residents received nail care on shower days and on an as needed basis. NA #7 reported she has been trained to clean and cut fingernails but had noticed Resident #40's fingernails were long and dirty when she came on to shift, 6/7/2024, at 7:00 am. NA #7 stated she had noticed if she had not cut and cleaned resident's fingernails "it was not getting done." NA #7 was asked to observe Resident #40's fingernails are agreed his fingernails were long, dirty, and needed to be cut

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 55	F 677		

and cleaned. NA #7 reported she would cut and clean Resident #40's fingernails before she left her shift.

An observation was conducted on 6/7/2024 at 2:41 pm. Resident #40 was observed to have had all 10 fingernails, on both his left and right hands, cut and cleaned.

An interview was conducted on 6/7/2024 at 9:05 am with the Director of Nursing (DON). The DON reported nail care should be completed on shower days and as needed. The DON reported the UM was new and was supposed to monitor nail care. The DON was not aware Resident #40 had long, dirty nails.

An interview was conducted on 6/7/2024 at 3:21 pm with the Administrator. The Administrator reported he would refer to the DON and indicated that there were designated staff to monitor nail care. The Administrator was not aware Resident #40 had long, dirty nails.

2. Resident #78 was admitted to the facility on 01/11/23 with diagnoses that included chronic obstructive pulmonary disease, diabetes, chronic pain, and others.

The quarterly Minimum Data Set (MDS) dated 05/03/24 revealed that Resident #78 was cognitively intact and required set up or clean up assistance with personal hygiene. No behaviors or rejection of care were noted.

Review of a care plan revised on 05/16/24 read, Resident #78 had an activity of daily living self-care performance deficit related to decrease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 677	Continued From page 56	F 677		

mobility, rheumatoid arthritis, and weakness. The interventions included: the resident requires up to extensive assistance of 1-2 person with personal hygiene.

An interview and observation were made with Resident #78 on 06/03/24 at 1:38 PM. Resident #78 was sitting beside her bed in her wheelchair, she was dressed in jeans and T-shirt and was well groomed. Her hair appeared clean, was not oily or greasy, but was long, shaggy and fell into her eyes anytime Resident #78 moved her head. Resident #78 was observed throughout the interview to push her hair out of her eyes. Resident #78 had a picture of herself from approximately six months ago and her hair was cut short and neatly styled. She stated that she had not had her hair cut since December 2023 and "I am in need of a cut." Resident #78 explained that in November 2023 a friend of hers that used to work in the activities department cut her hair, but she no longer worked at the facility and in December 2023 the facility had volunteer that came in and trimmed her hair, but she had not had a haircut or trim since then. Resident #78 stated that she had told the Nurse Supervisor, Human Resources, and the Administrator that she was in need a haircut.

An observation of Resident #78 was made on 06/04/24 at 3:24 PM. Resident #78 was up in her wheelchair at bedside and was reading a book. Her hair remained long and shaggy and would fall into her eyes while reading and she would have to sweep it to one side so she could see the book she was reading.

An interview was conducted with Social Worker (SW) #1 on 06/04/24 at 2:01 PM. She stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 677	Continued From page 57	F 677		

facility had not had a beautician since at least August 2023. She explained that they had someone who briefly volunteered to come and cut hair but that was short lived, and she could not recall when that was. SW #1 was not sure how the facility would handle if a resident needed or requested a haircut. She added she was unaware that Resident #78 wanted a haircut.

An observation of Resident #78 was made on 06/05/24 at 2:17 PM. Resident #78 was in the main dining room playing Bingo. Her hair remained long and shaggy and kept falling into her eyes while looking down at her bingo card. She was observed to keep sweeping her hair out of her eyes so she could see her Bingo card.

An interview was conducted with Medication Aide (MA) #3 and Nurse #14 on 06/06/24 at 10:48 AM, both stated that the facility did not have anyone to cut hair at this time. Both stated that they used to have someone who came around and cut hair but that was a while ago, but they could not recall how long ago.

Nurse #11 was interviewed on 06/06/24 at 10:50 AM. Nurse #11 stated she was not aware who would cut a resident's hair if they needed it or requested it. She added she did not think the facility had anyone that could cut hair at this time.

An interview was conducted with the Nurse Supervisor on 06/06/24 at 12:22 PM who stated that she had worked at the facility since April 2024 and before becoming the Nurse Supervisor she was a floor nurse. The Nurse Supervisor stated that when she was temporarily setting up her office in the beauty salon while the facility was under construction, she stated that Resident #78

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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F 677	Continued From page 58	F 677		

had inquired if she was the beautician because she needed their services. She added that the facility currently had no one to cut hair but management was interviewing for the position. The Nurse Supervisor stated, "I have not been shared the information on what to do if someone needs a haircut." She stated from time to time a family member would come in and cut their loved one's hair and of course if a resident had an appointment to get their haircut they would transport them to the appointment.

An interview was conducted with Human Resources on 06/06/24 at 2:22 PM. She stated that Resident #78 had not mentioned to her that she needed a haircut that she could recall and was unaware what the plan was if a resident needed a haircut, she would have to ask the Director of Nursing (DON).

The DON was interviewed on 06/06/24 at 11:11 AM. The DON stated that the facility currently did not have a beautician, however some families would come in and cut their loved one's hair. The DON stated there had been lots of residents over the last year and half that had requested a haircut, but they just did not have anyone that could do it. She explained that the facility was running ads online to hire someone that could cut hair at the facility but added they had not had anyone since January 2023 when she came to the facility. The DON added that the activities department had a volunteer that came in one time, but they have not had anyone since then and she could not recall when that was. The DON stated, Resident #78 was mobile so they could get her on the facility van and get her a haircut that would be no problem.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 677	Continued From page 59 The Administrator was interviewed on 06/06/24 at 4:10 PM who stated Resident #78 had not mentioned to him that she needed a haircut, and "she had no problem expressing herself." He stated, "we can get her a haircut no problem." The Administrator stated he had been at the facility for a few months and had been trying to hire someone, but it was difficult with the amount that they get for a haircut from Medicare/Medicaid. He stated that he had reached out to his corporation about possibly supplementing the rate. In addition, Human Resources had been in contact with the beautician from another facility that was familiar with the Medicare/Medicaid rate, and we were going to assist with buying her supplies, so he was hopeful that would work out. An observation and interview were conducted with Resident #78 on 06/07/24 at 3:05 PM. She was ambulating up the hallway with her walker, she kept sweeping her hair out of her eyes. She explained that the staff had come to take her to get a haircut and she asked how it was going to be paid for and no one could answer her. She stated that her insurance paid for a haircut every month so it should come out of her benefit money and since she had not used the benefit since last November, she wanted to make sure that the haircut would be paid for. She added she did not have the money to pay out of pocket but was waiting on someone to verify that her insurance benefit would cover it.	F 677		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring	F 678		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 678	Continued From page 60 such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Medical Director interviews the facility failed to ensure that Cardiopulmonary Resuscitation (CPR) was administered effectively when Resident #70 went into sudden cardiac arrest and CPR was initiated by Nurse Aide (NA) #3, NA #4, and NA #5 and continued for 7 minutes without a backboard. The backboard creates a hard surface for effective compressions that allow for adequate recoil (allowing the chest to fully expand after compression which pushes the blood to vital organs) and ensure perfusion for vital organs. During CPR Nurse #4 and the Staff Development Coordinator observed NA #3's compression were not effective or deep enough to create recoil and had to instruct NA #3 that his compressions were not deep enough before switching NA #3 out with another staff member that could assist. NA #3 and NA #4 were not certified in CPR for Healthcare Providers. Emergency Medical Services (EMS) arrived and placed a backboard under Resident #70 and continued CPR. Resident #70 expired. This deficient practice was for 1 of 1 resident reviewed who required CPR. Immediate Jeopardy began on 06/03/24 when staff administered CPR without the use of backboard and delivered compression that were not effective. Immediate jeopardy was removed on 06/12/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of a D	F 678	Resident #70 went into sudden cardiac arrest and CPR on 6/was initiated by 3 Nurse Aides (NA) without the use of a backboard and 2 of the NAs were without CPR certification. Starting 6/7/24, the Staff Development Coordinator (SDC) will complete an audit of the current CPR status of the nursing staff to include licensed nurses, certified nursing assistants, certified medication aides and agency nursing staff. The SDC will provide a CPR list of the nursing staff with current CPR certifications at each nursing station. Only certified CPR staff that are listed on the CPR list will be allowed to perform CPR. The Director of Nursing (DON), SDC, and nursing supervisor will be responsible for reviewing the daily staffing to ensure a CPR certified staff is working each shift. On 6/3/24, the 2 facility CPR carts were checked by the Staff Development Coordinator to ensure missing supplies were replaced on the carts and both carts have back boards. On 6/7/24, DON placed the crash cart checklist on nursing station #1□s crash cart and ensured that the crash cart checklist is in place on nursing station #2□s crash cart.	

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F 678	Continued From page 61 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. The findings included: Review of the facility's CPR policy revised April 2016 read in part, Requirements for CPR: 1. Personnel must provide basic life support, including CPR to a resident who requires such emergency care prior to arrival of emergency medical personnel. 2. Properly certified and trained staff must be available at all times. 3. Supplies (crash cart) a. backboard, b. face shield and resuscitator (ambu bag), c. automated external defibrillator (if available), d. oxygen mask, tubing, cannula, and tank, e. suction machine and equipment, and f. vital sign equipment to include pulse oximetry. Resident #70 was admitted to the facility on 11/15/23 with diagnoses that included Parkinson's disease, chronic respiratory failure, and history of pulmonary embolism. Review of a care plan initiated on 11/16/23 read, Advance Directive Full Code. The intervention included: advance directive will be followed as ordered. A physician order dated 04/12/24 read, Full code. The quarterly Minimum Data Set (MDS) dated 04/18/24 indicated that Resident #70 was cognitively intact, and he required assistance with activities of daily living. An interview was conducted with the Business	F 678	Starting 6/7/24, the SDC will educate the night shift licensed nurses on completing the crash cart checklist sheet on nursing station #1(100,200,300, 400 halls) and nursing station #2 (500, 600, 700 halls). The night shift licensed nurses will be responsible for completing the crash cart checklists each night and ensuring the carts are stocked, and the back boards are in place. On 7/1/24, the SDC position was filled with current facility staff. SDC from sister facility will continue to provide additional facility SDC support and orientation for the new SDC. All the current residents who have full code status are at risk as a result of this deficient practice. Starting 6/7/24, the Director of Nursing, Unit Manager, and the Staff Development Coordinator (SDC) will educate the nursing staff to include the licensed nurses, certified medication aides, and the certified nursing assistants on the CPR policy to include ensuring only nursing staff certified to perform CPR with current CPR certification status will be allowed to perform CPR, and making sure the back board is in place before initiating CPR to ensure that chest compressions are effective and allow for chest recoil. A list of the nursing staff with current CPR certifications will be placed at each nursing station. Nursing staff will not be	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 678	Continued From page 62 Office Manager on 06/06/24 at 10:10 AM, she stated that she was completing her angel rounds in the facility on 06/03/24 and she went into Resident #70's room and he did not look right. She stated she asked Resident #70 if he was ok, and he did not respond so she went and asked NA #4 to come and check on him. She stated that when NA #4 saw Resident #70's he stated "he passed away" but all the nurses came and started life saving measures and she stayed out of the way. An interview with the Activity Assistant was conducted on 06/06/24 at 10:13 AM who stated on 06/03/24 she was passing out activity information to the residents and the Business Office Manager said Resident #70 does not look right. She stated she went into his room, and he was sitting straight up in bed with his head on the pillow and was white as snow with black lips. The Activity Assistant stated that they grabbed NA #4 and the Director of Nursing (DON), and nursing staff attempted life saving measures. The Scheduling Coordinator was interviewed on 06/07/24 at 9:45 AM. She stated on 06/03/24 the DON had instructed her to overhead page Code Blue and to call EMS. She stated she stayed on the phone with EMS until they arrived at the facility with the DON next to her in case, they needed any information that she could not provide. A continuous observation was made on 06/03/24 at 9:48 AM to 10:13 AM. At 9:48 AM an overhead page was heard in the facility "Code Blue" Resident #70's room number, Upon arrival at Resident #70's room, the surveyors stood in the hallway outside of Resident #70's room where the	F 678	allowed to perform CPR without their name listed on the CPR list and without a current CPR certification. The CPR list will be updated weekly by the SDC, to include newly hired and/or agency staff□s CPR expiration and renewal dates. Staff who have not completed the required education by 7/16/24 will not be able to work until the education is completed. On 6/11/24, the Director of Nursing/Staff Development Nurse conducted a mock Code Blue drill for training purposes on the 7am -7pm shift and 7pm- 7am shift. The Director of Nursing/Staff Development Nurse will conduct a mock Code Blue drill monthly thereafter. There were no concerns observed. Starting 6/10/24, the Staff Development Coordinator (also a Certified CPR instructor) will begin teaching the American Heart Association CPR class and certifying staff pending their post class passing test scores. The class will be provided for staff whose CPR certifications are expired or staff without CPR certification. Starting 6/7/24, the Director of Nursing and the SDC will educate the licensed nurses on ensuring that the CPR crash carts are being checked daily, after use and the back board is in place. The night shift licensed nurses will be responsible for completing the crash cart checklist sheet each night and ensuring that the CPR crash carts are stocked, and the	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 678	Continued From page 63 scene was visible but not in the way of emergency personnel. There were three male NAs later identified as NA #3, NA #4, and NA #5 starting Cardiopulmonary Resuscitation (CPR). Resident #70 was pale but had no signs of lividity (pooling of blood) and did not appear rigid. After lowering the head of Resident #70's bed NA #5 began performing chest compressions without placing a backboard under Resident #70. When the crash cart arrived at the room at 9:52 AM NA #4 began delivering rescue breathes via an ambu bag (artificial manual breathing unit). NA #4 and NA #5 continued to provide rescue breaths and compression for 5 minutes when NA #5 stopped compressions and NA #3 started compressions. The Staff Development Coordinator who was observed to deliver the facility's crash cart and vital sign machine at 9:52 AM, arrived at the room along with Nurse #4 and began assisting. Nurse #4 was overheard instructing NA #3 that his compressions were not deep enough, and he needed to push harder to create recoil. NA #3 was overheard saying he did not want to break Resident #70's ribs. Nurse #4 continued to coach NA #3 until she took over compressions. At 9:55 AM EMS and fire rescue arrived on scene and began questioning why Resident #70 was not on a backboard. When the Captain of Fire Rescue asked about the backboard, the Staff Development Coordinator began attempting to remove the headboard from the bed but was initially unable to remove it. After multiple attempts to remove the headboard the Staff Development Coordinator realized that there was pins holding the headboard in place, she pulled the pins and the headboard was removed. Staff were observed to remove the headboard of the bed and log roll Resident #70 onto his side and place the headboard under Resident #70 at 9:57	F 678	back boards are in place. The DON will be responsible for checking the CPR crash carts and reviewing the daily CPR crash cart checklist for completion weekly to ensure continual compliance. Starting 6/7/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring all nursing staff to include licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), weekend, agency and prn staff receive the CPR education. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff. Staff who have not completed the education by 7/17/24 will not be allowed to work until the education is completed. The CPR training will be provided by another Maple Health SDC who is a CPR instructor as well as the facility staffing coordinator who is a CPR instructor. The Director of Nursing will report results of CPR crash cart checks, updates to the CPR list, and Mock Codes to the Quality Assurance Improvement Performance (QAPI) committee for review/revision and to ensure continual compliance.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 678	Continued From page 64	F 678		

AM and then EMS continued CPR efforts. At 10:03 AM the Captain of the Fire Rescue demanded to see the Director of Nursing (DON) and when she arrived at the room inquired why there was no backboard under Resident #70 when CPR was initiated. He stated, "this is a skilled nursing facility, and they should have the needed equipment in place when we get here." EMS continued with rescue efforts, but they were unsuccessful, and they called time of death 10:13 AM.

The EMS report dated 06/03/24 read in part, patient was found by staff pulseless and apneic in his room but still warm to touch. CPR started. Arrived on scene, patient found pulseless and apneic and staff started CPR 5 minutes ago. He has a history of respiratory failure and pulmonary embolism. His skin is mottled, and he appears to have a bluish hue from the neck up.

NA #5 was interviewed on 06/03/24 at 1:53 PM and stated that someone he could not recall who, alerted him that Resident #70 did not have a pulse and was pale. NA #5 stated that he was CPR certified and he went into Resident #70's room and began chest compressions until the crash cart arrived with the ambu bag. He stated that NA #4 began using the ambu bag and he continued chest compressions until he got tired and then he switched off with NA #3. NA #5 stated he did what he was trained to do in his CPR class. NA #5 was also unaware where the crash cart and back board were located. NA #5 stated he had been trained to verify code status and initiate compressions, which is what he did.

NA #4 was interviewed on 06/05/24 at 3:20 PM, who stated on 06/03/24 he was passing out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 678	Continued From page 65	F 678		

isolation gowns going from room to room and when he got to Resident #70's room he was sitting straight up in bed and was slumped over. NA #4 stated he immediately went and got the DON from her office and when he returned to the room NA #5 was putting the head of bed down to start chest compressions. Nurse #4 arrived at the room and when the crash cart arrived, she started using the "bag" and after about 5 minutes NA #5 got tired and they switched off. NA #4 stated he did compressions for a bit and then switched off with NA #3. He added that they did not have a backboard under Resident #70 until EMS arrived and he heard them ask where the backboard was located. NA #4 stated when EMS arrived, he stepped out of the way. He added that he had completed his CPR training online, but his certification had expired. NA #4 stated he had some training when he was hired but could not recall what they trained him on and added he did not do direct patient care very often because his main job was central supply. During compression NA #4 stated he was counting them and someone else was using the "bag."

NA #3 was interviewed via phone on 06/06/24 at 8:57 AM. NA #3 stated that on 06/03/24 he arrived at work at 7:05 AM and started his rounds working from the bottom of the hall to the top. He stated he went in and spoke to Resident #70, and the resident appeared to be his usual self. He stated that breakfast trays arrived at the unit, and he passed those out and began assisting some of the residents that needed assistance. NA #3 stated he had just finished feeding one of his residents and walked out into the hallway and heard two staff members, one from the business office and one from activities but he did not know their names saying that something was wrong

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 678	Continued From page 66	F 678		

with Resident #70, so he went to go and check on him. He stated when he got to the room, he could tell that something was wrong, so he went to alert the DON. He stated that staff began to arrive at the room, and someone began chest compressions until the crash cart arrived, but he was not sure who. NA #3 stated that he did assist with chest compressions and recalled Nurse #4 telling him his chest compressions had to be deeper. NA #3 stated he was hesitant because he did not want to crack Resident #70's bones and the Staff Development Coordinator took over compressions until EMS arrived. He stated that he stayed back out of the way until EMS arrived then he left room. He added that he had only been employed at the facility for a short time and his CPR certification had expired and was no longer valid. NA #3 stated that he did realize that there was no backboard under Resident #70 but was not sure if they needed one or not.

A nurses note dated 06/03/24 at 7:34 PM written by Nurse #4 read; Resident was found unresponsive with brown vomit coming from his mouth. His pulse was checked, and chest compressions initiated and continued until EMS arrived. The time of death was 10:13 AM per EMS and fire department. Resident's family members, the DON and covering Medial Director (MD) were notified. Funeral home was called to pick up the resident body. The body left at 2:06 PM. No medication or treatment rendered.

Nurse #4 was interviewed via phone on 06/06/24 at 9:08 AM. Nurse #4 recalled that on 06/03/24 she was at her medication cart on the 200 hall, and someone told her that there was a code in the building on the 400 hall. Nurse #4 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 678	Continued From page 67	F 678		

secured her medication cart and went to Resident #70's room. The Staff Development Coordinator had gone to get the crash cart and vital sign machine. Compressions had already been started by NA #5 and she stated she told NA #5 if he got tired to let her know. She stated when the Staff Development Coordinator returned with the vital sign machine, she checked vital signs and there were none. Nurse #4 stated she realized at that time that there was no backboard under Resident #70. She stated that the staff attempted to get the headboard off the bed to place under him but there were pins holding it in place. Once they were able to get the pins out, they pulled the headboard off, log rolled Resident #70 onto his side and put the headboard under him. Nurse #4 stated it was very chaotic and she could not recall the actual sequence of events but at some point, NA #3 switched over to do compressions on Resident #70 and she realized that his compressions were not effective and there were not creating recoil. Nurse #4 stated NA #3 stated that he did not want to break Resident #70's rib and "I coached him and told him to go deeper your compressions have to be effective." When Nurse #4 realized that NA #3's compressions were still not effective they switched off to another staff member. Shortly after that EMS and fire rescue arrived and took over the scene. Nurse #4 stated she was not aware that the facility's backboard was not on the crash cart but knew that it was supposed to be on the cart. Nurse #4 confirmed that she was trained in CPR by the American Heart Association but had not received any training on cardiac arrest or emergency response in the facility.

The Staff Development Coordinator was interviewed on 06/06/24 at 10:27 AM. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 678	Continued From page 68	F 678		

she started with the facility last week and on Monday morning she saw the DON in the hallway, and she asked her to go to [Resident 70's room] and run the code. The DON asked her to grab the crash cart, but she did not know where it was located and was told it was in the conference room. The Staff Development Coordinator explained after grabbing the crash cart from the conference room she took it to Resident #70's room and handed the ambu bag over to Nurse #4 and the staff that were in the room performing compressions switched positions. She stated when she arrived at Resident #70's room chest compressions were already in progress by Nurse #4, and she believed NA #3 and NA #4 were also in the room. Nurse #4 asked her to get the vital sign machine, so she did and when she returned to the room NA #3 was delivering chest compressions. The Staff Development Coordinator stated that she did realize that there was not a backboard under Resident #70, and she knew that there was not a backboard on the crash cart, and she thought it was better to start chest compressions without it then to take the time to search the building for the backboard. While NA #3 was delivering compressions she realized that his compressions were not effective, and she tried to coach NA #3, but he stated that he was worried about cracking Resident #70's ribs. The Staff Development Coordinator stated she took over compressions from NA #3 until EMS arrived on the scene. She added that they were able to remove the headboard of the bed and place that under Resident #70 and continued CPR with EMS taking over the scene.

The DON was interviewed on 06/06/24 at 11:14 AM. The DON stated on 06/03/24 NA #4 came to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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F 678	Continued From page 69	F 678		

her office and told her to come to Resident #70's room. She stated when she went to Resident #70's room he had no radial pulse and was warm to touch, and the Medication Aide was behind her at her computer and stated Resident #70 was a full code. The DON stated she instructed the Scheduling Coordinator to overhead page code blue and to call EMS. The DON stated all the nursing staff started to arrive at Resident #70's room, the Staff Development Coordinator grabbed the crash cart, and they began CPR. The DON stated she did not participate in CPR and stayed out of the way of the other nursing staff. She was unaware that NA #3 and NA #4 that were participating in CPR were not trained, and that the compressions NA #3 were delivering were not effective until today. The DON stated that anyone that was not trained in CPR should not administer CPR. She explained she had been at the facility since January 2023, and she had not had consistent staff and no one to oversee the training program. The Staff Development Coordinator was only recently hired and had not had time to develop and implement all the things that needed to be done at the facility. The DON further explained the backboard was supposed to be on the crash cart so all the required equipment would be available to the staff and the staff should have put the backboard under Resident #70 before beginning chest compressions. The DON also confirmed that the staff were not aware the crash cart was in the conference room due to the remodeling of the nursing station office and that they should have been aware of where the crash carts were located.

An observation of the crash cart at nursing station #1 (100/200/300/400) nursing station on 06/06/24 at 12:35 PM revealed the cart to be stocked with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 678	Continued From page 70	F 678		

an ambu bag and backboard along with numerous others supplies that would be required for an emergency. There was no checklist located on the cart.

The Administrator was interviewed on 06/06/24 at 4:10 PM who stated he had been at the facility for a few months. He stated that until recently they had a vacancy in the Staff Development Coordinator position and that there was a lot gaps in the training program that they were trying to get filled. The Administrator stated that if staff were not certified in CPR, then they should not have been participating in CPR and the staff that were involved should have ensured the correct equipment was being used.

The Medical Director (MD) was interviewed on 06/05/24 at 2:55 PM. She stated that the DON had called and told her about Resident #70 on 06/03/24. She stated that Resident #70 had severe Parkinson's disease and had declined since coming to the facility. The MD stated that potentially Resident #70 may have aspirated but she was not for sure. The MD stated she was not familiar with the protocol for CPR or Emergency Response in the building, but she had always told the facility to call EMS before calling her. She stated that only staff trained in CPR should be performing CPR and the trained staff should know the basics of CPR which included placing a backboard under the resident to ensure effective chest compressions. The MD stated I do not think that not having a backboard under Resident #70 would have changed his outcome.

The Administrator was notified of the immediate jeopardy on 06/05/24 at 5:13 PM.

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 678	Continued From page 71	F 678		

The facility provided the following credible allegation of immediate jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to ensure that Cardiopulmonary Resuscitation (CPR) was administered effectively when Resident #70 went into sudden cardiac arrest and CPR was initiated by 3 Nurse Aides (NA) without the use of a backboard and 2 of the NAs were without CPR certification.

Starting 6/7/24, the Staff Development Coordinator (SDC) will complete an audit of the current CPR status of the nursing staff to include licensed nurses, certified nursing assistants, certified medication aides and agency nursing staff. The SDC will provide a CPR list of the nursing staff with current CPR certifications at each nursing station. Only certified CPR staff that are listed on the CPR list will be allowed to perform CPR. The Director of Nursing (DON), SDC, and nursing supervisor will be responsible for reviewing the daily staffing to ensure a CPR certified staff is working each shift.

On 6/3/24, the 2 facility CPR carts were checked by the Staff Development Coordinator to ensure missing supplies were replaced on the carts and both carts have back boards.

On 6/7/24, the DON will place the crash cart checklist on nursing station #1's crash cart and ensure that the crash cart checklist is in place on nursing station #2's crash cart.

Starting 6/7/24, the SDC will educate the night

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 678	Continued From page 72	F 678		

shift licensed nurses on completing the crash cart checklist sheet on nursing station #1(100,200,300, 400 halls) and nursing station #2 (500, 600, 700 halls). The night shift licensed nurses will be responsible for completing the crash cart checklists each night and ensuring the carts are stocked, and the back boards are in place.

All the current residents who have full code status are at risk as a result of this deficient practice.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Starting 6/7/24, the Director of Nursing and the Staff Development Coordinator (SDC) will educate the nursing staff to include the licensed nurses, certified medication aides, and the certified nursing assistants on the CPR policy to include ensuring only nursing staff certified to perform CPR with current CPR certification status will be allowed to perform CPR, and making sure the back board is in place before initiating CPR to ensure that chest compressions are effective and allow for chest recoil. A list of the nursing staff with current CPR certifications will be placed at each nursing station. Nursing staff will not be allowed to perform CPR without their name listed on the CPR list and without a current CPR certification. The CPR list will be updated weekly by the SDC, to include newly hired and/or agency staff's CPR expiration and renewal dates.

By 6/11/24, the Director of Nursing/Staff Development Nurse will conduct a mock Code Blue drill for training purposes on the 7am -7pm

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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F 678	Continued From page 73	F 678		

shift and 7pm- 7am shift. The Director of Nursing/Staff Development Nurse will conduct a mock Code Blue drill monthly thereafter.

Starting 6/10/24, the Staff Development Coordinator (also a Certified CPR instructor) will begin teaching the American Heart Association CPR class and certifying staff pending their post class passing test scores. The class will be provided for staff whose CPR certifications are expired or staff without CPR certification.

Starting 6/7/24, the Director of Nursing and the SDC will educate the licensed nurses on ensuring that the CPR crash carts are being checked daily, after use and the back board is in place. The night shift licensed nurses will be responsible for completing the crash cart checklist sheet each night and ensuring that the CPR crash carts are stocked, and the back boards are in place. The DON will be responsible for checking the CPR crash carts and reviewing the daily CPR crash cart checklist for completion weekly to ensure continual compliance.

Starting 6/7/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring all nursing staff to include licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), weekend, agency and prn staff receive the CPR education. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff.

Effective 6/7/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged

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F 678	Continued From page 74 non-compliance. Alleged Date of IJ Removal: 6/12/24 A validation of immediate jeopardy removal was conducted on 06/13/24. The list of current staff certified in CPR was located in a binder at each nursing station. In addition, those staff that were certified were highlighted on the daily schedule, so they were easily identified by all staff. Both crash carts were located in the building, one at each nursing station, the logbook was on each cart and had been checked each night since 06/03/24. A mock "code blue" had been conducted on each shift and staff responded accordingly. Interviews with the scheduling coordinator revealed that she ensured staff certified in CPR were scheduled on each shift. Interviews with other nursing staff revealed that they had been educated on where the crash carts were located, their role in emergency response, and how to identify which staff were certified in CRP. They were also able to verbalize that only staff certified in CPR should participate in CPR. The IJ removal date of 06/12/24 was validated.	F 678		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 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	F 684		7/17/24

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F 684	Continued From page 75 by: Based on record review, and Resident, staff, Physician Assistant (PA), and Medical Director (MD) interviews the facility failed to perform a comprehensive assessment including vital signs before moving a resident off the floor after a fall with injury and failed to seek immediate medical treatment or higher level of care. On 5/27/2024 at 10:40 pm Nurse #1, Nurse #2, Nurse #3, Nurse Aide (NA) #1, and NA #2 responded to Resident #40's room after they heard Resident #44 yell that Resident #40 was on the floor. Resident #40 was found face down on the floor. Nurse #1 and Nurse #2 rolled Resident #40 over, transferred Resident #40 by picking him up under his arms while NA #1 held "traction" to Resident #40's left leg. When Resident #40 was placed back in bed, Nurse #3 assessed Resident #40 and obtained vital signs at which time she noticed Resident #40's left leg was internally rotated and shorter than the right leg. Nurse #3 immediately summoned Emergency Medical Services (EMS) but after review of his chart and speaking to the Director of Nursing (DON), she was instructed to cancel EMS because Resident #40 had an advance directive that indicated "Do Not Hospitalize" unless his comfort needs could not be met at the facility. An x-ray was performed on 5/28/2024 which revealed Resident #40 had sustained an acute fracture of the proximal left femur (thigh bone). Resident #40 was transferred to the hospital on 5/28/2024 where he was admitted for further evaluation and pain management. The facility also failed to follow up with a provider about an abnormal radiology report, failed to obtain ordered laboratory testing, failed to ensure the necessary diagnostics were completed for a resident (Resident #196) that had confusion reported by the RP on 12/24/2023, and	F 684	The facility failed to thoroughly assess resident #40 on 5/27/24 at 10:40 pm after he fell from his wheelchair to the floor on his left side face down. Resident #40 was discovered by his roommate who summoned assistance from staff. Nurse #1, Nurse #2, NA #1, and NA #2 lifted resident #40 under his arms and held traction to Resident #40's left leg and picked him up from the floor and placed him in the bed. Nurse #3 completely assessed Resident #40 and observed that the left leg was internally rotated and shortened. Nurse #1 described left leg as a "limp noodle." Nurse #3 immediately summoned Emergency Medical Services (EMS) but after speaking to the Director of Nursing (DON) Nurse #3 cancelled EMS even though Resident #40 had obvious deformity that warranted a higher level of care to manage the resident's comfort needs which could not be met in the facility. On 5/28/24, Resident #40 was further assessed by the provider and sent to the emergency room. On 6/10/24, the Director of Nursing (DON) reviewed the falls for the last 30 days to ensure residents were assessed by licensed nurses identifying obvious injuries prior to being moved and determine if the resident required a higher level of care. There were no concerns identified. All the current residents with falls are at risk as a result of this deficient practice. On 6/10/24, the Chief Nursing Officer educated the Director of Nursing on	

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F 684	Continued From page 76 failed to immediately initiate Emergency Medical Services (EMS) when Resident #196 was only responsive to painful stimuli. Resident #196 was transferred to the hospital on 12/26/2023 at 2:04 pm and was admitted for respiratory failure and placed on Bilevel Positive Airway Pressure (BiPAP, non-invasive ventilator). The deficient practice occurred for 2 of 3 residents reviewed for change of condition (Resident #40 and Resident #196). Immediate jeopardy began on 5/27/2024 when nursing staff failed to assess or obtain vital signs prior to moving Resident #40 after finding him face down on the floor and failed to follow through with emergency medical services for a resident with obvious signs of injury. Immediate jeopardy was removed on 6/12/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "G" (actual harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Example #2 is being cited at a lower scope and severity of a "G." The findings included: Resident #40 was admitted to the facility on 5/19/2018. His recent diagnosis as of January 2024 included dislocation of the internal left hip and was deaf and mute. Review of a Medical Order for Scope of Treatment dated 7/13/2023 completed by PA #1 revealed Resident #40 did not want to be resuscitated if he had no pulse and was not	F 684	directing staff calls regarding falls with injury to review residents' MOST forms and if the facility's unable to keep the resident comfortable, notify the family and call EMS to transport to a higher level of care as needed. The Director of Nursing will educate licensed nurses on assessing resident status post falls, to include vital signs, neuro checks, range of motion, skin assessment and pain assessment, prior to being moved. Residents assessed with obvious injuries will be transferred to a higher level of care warranted by their MOST form. The Director of Nursing and clinical team will review falls daily, in clinical meetings, to ensure assessments were completed and if indicated, residents receive a higher level of care. The MOST forms will be reviewed/updated weekly and/or changes in condition by the Social Workers and kept in a binder at both nursing stations. Residents without a MOST form, Staff will notify Resident/Resident's responsible party, along with the provider, on assessment findings and guidance to determine if a higher level of care and services are warranted. Starting 6/5/24, the Director of Nursing and the SDC will educate the licensed nurses to review resident MOST forms before calling Emergency Medical Services and if obvious deformity to include indications of fracture are observed residents should be immediately transferred to a higher level of care because resident's comfort needs cannot	

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F 684	Continued From page 77 breathing. The MOST form stated Resident #40 wanted comfort measures to include "keep clean, warm dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort." Resident #40 was not to be transferred to the hospital unless comfort needs could not be met in the facility. A quarterly Minimum Data Set (MDS) dated 5/8/2024 revealed Resident #40 was severely cognitively impaired. Resident #40 was coded as no impairment of his upper extremities, impairment on one side of his lower extremities. Resident #40 was coded as maximum assist for chair/bed to chair transfers. Resident #40 was coded as requiring substantial/maximal assistance with bed mobility, sitting to standing, lying to sitting, was not ambulatory, and used a wheelchair. A review of the care plan dated 5/8/2024 revealed Resident #40 required partial to moderate assistance with transfers. An interview was conducted on 6/3/2024 at 10:59 with Resident #44. Resident #44 reported Resident #40 had fallen approximately one week ago. Resident #44 reported he had returned to his room at night after going outside and found Resident #44 lying face down on the floor. Resident #44 stated he yelled for help and multiple staff members arrived. Resident #44 stated he told nursing staff in the room not to move Resident #40 until EMS could assess him because he was afraid Resident #40's leg was broken. Resident #44 stated Resident #40 was sent to the Emergency Department the next day	F 684	be met at the facility. Starting 6/5/24, the Director of Nursing and the Staff Development Coordinator will educate all staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), licensed nurses, therapy staff, housekeeping/ laundry staff, dietary staff, social services, administrative staff, weekend staff, agency and prn staff on ensuring that residents that experience falls are not moved prior to an assessment by a licensed nurse and reporting any changes from baseline immediately to the nurse. Starting 6/5/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring all staff to include licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), dietary staff, social services, housekeeping/laundry staff, therapy staff, maintenance staff, administrative staff, weekend staff, agency staff and prn staff receive the education by 7/16/24. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff. The SDC will be responsible for ensuring the education is completed. The Director of Nursing will review falls 3x weekly x 8 weeks and monthly x 2 months to ensure fall assessments are	

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F 684	Continued From page 78 and was found to have a broken leg. An interview was conducted on 6/4/2024 at 4:51 pm with Nurse #1. Nurse #1 reported she worked night shift (7:00 pm to 7:00 am) on 5/27/2024 on 400 hall and was passing medications when she heard Resident #44 yell that Resident #40 was on the floor. Nurse #1 stated she, NA #1, and NA #2 ran into Resident #40's room. Nurse #1 stated Resident #40 was found lying on his left side in a "fetal position" and appeared to have his left hand under his left hip. Nurse #1 reported that Nurse #2 arrived in the room, and they all rolled Resident #40 over. Nurse #1 reported she thought that something was wrong with his left hip. Nurse #1 reported she thought Resident #40 had recently had hip surgery and wanted to get him off the hard floor, which is why she had not assessed him and obtained vital signs prior to transferring Resident #40 into bed. Nurse #1 reported that she, in addition to Nurse #2, NA #1, and NA #2 picked Resident #40 off the floor and placed him in bed and recalled his left leg as looking like a "limp noodle." An attempt to speak to Nurse #2 was made on 6/4/2024 and was unsuccessful. An interview was conducted on 6/4/2024 at 7:26 pm with NA #2. NA #2 reported she worked night shift (7:00 pm to 7:00 am) on 5/27/2024 and was assigned to the 400-hall. NA #2 reported she heard Resident #44 yell that Resident #40 was on the floor. NA #2 reported when she arrived in the room, Resident #40 was lying next to the wheelchair and appeared to have his right leg under the wheelchair. She reported Resident #40 was on his left side in a fetal position. NA #2	F 684	completed, resident are not being moved prior to a licensed nurse complete assessment and residents receive higher level of care if indicated. The Director of Nursing will report findings to the Quality Assurance Performance Improvement (QAPI) committee for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 684	Continued From page 79	F 684		

reported Resident #40's leg was moved when they rolled him onto his back. NA #2 stated that she had assisted Nurse #1, Nurse #2, and NA #1 as they transferred Resident #40 to the bed by helping lift under his arms. NA #2 stated she was not able to recall Nurse #1, Nurse #2, or Nurse #3 assessing Resident #40 until Resident #40 was in the bed. NA #2 stated she observed Resident #40's leg to "not look right" and appeared to be "disfigured." NA #2 reported someone obtained vital signs after Resident #40 was placed back in the bed.

An interview was conducted on 6/4/2024 at 7:57 pm with NA #1. NA #1 reported she worked night shift (7:00 pm to 7:00 am) on 5/27/2024 and was assigned 200 and 400 halls. NA #1 reported she was in the hall when she heard Resident #44 yell that Resident #40 was on the floor. NA #1 stated when she arrived at the room, Resident #40 was laying on his left side and appeared to have his right leg tangled in the wheelchair. NA #1 reported Resident #40's leg was moved from under the wheelchair when they rolled him over in the floor. NA #1 stated Nurse #1 thought Resident #40's leg was broken, and stated Resident #40 needed to be placed in the bed. NA #1 reported she held "traction" to Resident #40's left leg and kept it straight while the Nurse #1, Nurse #2, and NA #2 picked Resident #40 up using his arms. NA #1 reported traction was the pull and hold the leg in a neutral position. NA #1 reported she had been an Emergency Medical Technician (EMT) in the past, but that she did not function as one at the facility.

A review of an incident report dated 5/27/2024 at 10:40 pm completed by Nurse #3 revealed Resident #40 was found lying face down on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 80	F 684		

floor beside the bed. An assessment revealed Resident #40 had internal rotation and shortening of the left leg, a small head laceration to the top of the scalp, and a small laceration to the left outer ankle.

An interview was conducted on 6/4/2024 at 12:38 pm with Nurse #3. Nurse #3 reported she was passing medications on 300-hall when NA #1 and NA #2 came to tell her that Resident #40 was lying on the floor by the bed. Nurse #3 reported that when she arrived in Resident #40's room, Nurse #1, Nurse #2, NA #1, and NA #2 were transferring Resident #40 into bed. Nurse #3 stated after Resident #40 was in the bed she performed an assessment by asking him if he was okay and got his vital signs. Nurse #3 reported she observed his left leg internally rotated and shorter than his right leg. Nurse #3 stated she instructed another staff member to call 911 and began to print out his paperwork at which time she noticed Resident #40 had a "Do not hospitalize" order in his Electronic Medical Record (EMR). Nurse #3 reported she immediately called the Director of Nursing (DON) and was instructed by the DON to cancel Emergency Medical Services (EMS) and contact the on-call provider because the family would not want Resident #40 to be sent to the hospital. Nurse #3 stated she cancelled EMS and contacted the on-call provider, PA #2, that Resident #40 had internal rotation and shortening of his left leg, at which time PA #2 ordered Ibuprofen 600 milligrams (mg) one time for pain and was instructed to perform neurological checks every four hours. Nurse #3 stated if she had gotten to the room prior to Nurse #1, Nurse #2, NA #1, and NA #2 transferring Resident #40 to bed, she would have instructed them not to move him until she had assessed him and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 81	F 684		

obtained vital signs.

A physician's order dated 5/27/2024 at 10:54 pm for Resident #40 revealed an order for an x-ray of the left hip and pelvis written by the MD. The order was entered by Nurse #3 after she called to report Resident #40's left leg was internally rotated and shorter than his right leg.

The pain documentation, on the MAR, from 5/27/2024 through 5/28/2024 revealed Resident #40 experienced pain 6 out of 10 during day shift on 5/28/2024 with no time noted and 8 out of 10 on 5/28/2024 at 12:19 pm prior to being transferred to the hospital.

A radiology report dated 5/28/2024 at 9:37 am revealed Resident #40 had a dislocation of a left hip arthroplasty (a surgery to restore the hip joint) and an acute fracture of the proximal (close to the hip) left femur noted as new since 1/12/2024.

Nurse #10 documented that she administered oxycodone-acetaminophen 5-325 mg tablet on 5/28/2024 at 12:00 pm, as scheduled (6:00 am, 12:00 pm, 6:00 pm, 12:00 am), and documented a pain assessment of 8 out of 10 for Resident #40.

The physician's orders dated 5/28/2024 at 12:15 pm written by PA #1 revealed Resident #40 was to give another dose oxycodone-acetaminophen 5-325 mg tablet, one time only, for increased pain.

Nurse #10 documented that she administered oxycodone-acetaminophen 5-325 mg tablet on 5/28/2024 at 12:19 pm, one time, and documented a pain assessment of 8 out of 10 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 82	F 684		

Resident #40.

A review of a PA #1's progress noted dated 5/28/2024 revealed Resident #40 was seen after he fell from bed during the night (5/27/2024). Resident #40 had complained of pain. An x-ray was obtained that revealed a fracture of the left femur with lateral displacement. The PA spoke with the Resident Representative (RR) who agreed to have Resident #40 sent to the hospital for evaluation and possible reduction.

On 5/28/2024 at 1:15 pm, PA #1 ordered Resident #40 to be transferred to the hospital.

An interview was conducted on 6/4/2024 at 3:19 pm with PA #1. PA #1 reported she was made aware of Resident #40's fall the following day, 5/28/2024 when she arrived at the facility. PA #1 stated she was very familiar with Resident #40 and could tell on 5/28/2024 he was in a lot of pain and was grimacing. PA #1 reported she ordered an additional pain pill to be administered, and ultimately sent him to the hospital for further evaluation. The PA stated Resident #40's leg did not appear to be "in the neutral position it should be in." The PA stated she ordered an x-ray on 5/28/2024 which revealed an old dislocation and a new fracture. The PA reported she was not aware staff had transferred Resident #40 back to bed prior to assessing him and obtaining vital signs. The PA stated that if Resident #40's leg was stabilized she could not see a problem with moving him prior to performing an assessment and obtaining vital signs. The PA reported that the facility staff always do things the way they are supposed to and follow protocol. The PA was unsure of what the facility's protocol was for assessing a resident after a fall. The PA reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 83	F 684		

after she received the x-ray results, she contacted the family, and sent Resident #40 to the Emergency Department for further evaluation. PA #1 verified she had received the x-ray results on 5/28/2024 at 9:37 am but had difficulty reaching Resident #40's RR to get permission to transfer him to the hospital, which caused a delay in his transfer to the hospital. PA #1 reported she was not an expert in orthopedics and was not familiar with traction.

The Emergency Medical Services (EMS) report dated 5/28/2024 at 1:43 pm revealed Resident #40 had pointed to his left leg, and "made a grimacing face as if to say that it hurt" and there was "obvious deformity" noted in the left hip with inward rotation.

Review of ED department evaluation on 5/28/24 Resident #40 presented to the Emergency department after he fell to the ground while transferring from his bed on 5/27/2024. Documentation revealed Resident #40 was complaining of pain and appeared to be less ambulatory. Resident #40 had an x-ray of his left hip and pelvis that demonstrated left hip arthroplasty with an associated fracture dislocation. Resident #40 was admitted to the facility for further evaluation and pain management medications were adjusted (he was administered hydrocodone-acetaminophen 5-325 mg every 6 hours) and his oxycodone was continued. Resident #40 was recommended nonsurgical interventions, he was not a surgical candidate, and was to follow up in two weeks with outpatient orthopedics. Resident #40 was discharged back to the facility on 5/29/2024.

A review of the June 2024 MAR revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 84	F 684		

Resident #40 had received oxycodone-acetaminophen 5-325 mg on 6/4/2024 at 12:00 pm, as scheduled.

An observation and interview were conducted on 6/4/2024 at 1:16 pm. Resident #40 was lying in bed turned on his right size and pointed to his left upper outer thigh area, made a grimacing face and a squeezing motion with his hands. Resident #40 nodded "yes" that he had pain and mouthed the pain medication only "helped a little."

An interview was conducted on 6/5/2024 at 8:41 am with the Director of Nursing (DON). The DON reported she was aware of Resident #40's fall on 5/27/2024. The DON reported she was not aware Nurse #1, Nurse #2, and Nurse #3 failed to assess Resident #40 and obtain vital signs prior to transferring him to bed. The DON stated she expected staff to assess the resident for physical injury/deformity, pain, mental status changes, and obtain vital signs prior to moving a resident after a fall. The DON acknowledged staff could have caused additional harm to the resident if they were not assessed prior to being moved after a fall. The DON stated a Nurse should have assessed Resident #40 prior to transferring him back to bed. She further stated the facility had not investigated the incident because they knew he had fallen. The DON stated Nurse #3 should have contacted the family about Resident #40's condition and to get permission to send Resident #40 to the hospital on the night of the fall, 5/27/2024. The DON reported there was confusion because his advanced directives said to "Do Not Hospitalize," so she advised staff to get RP permission. Nurse #3 was sending the resident out and the DON stopped her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 85	F 684		

An interview was conducted on 6/5/2024 at 3:09 pm with the MD. The MD reported she had been made aware on 5/28/2024 of Resident #40's fall on 5/27/2024 by PA #1. The MD stated PA #1 had Resident #40 sent to the hospital for evaluation because she was concerned how his leg looked. The MD was not aware Resident #40 had been transferred to the bed prior to being assessed or having vital signs obtained. The MD stated the Nurse should have performed a quick assessment to ensure Resident #40 was breathing and had no obvious deformity prior to moving him. The MD stated if there was obvious deformity staff could cause additional harm to the resident.

An interview was conducted on 6/7/2024 at 3:23 pm with the Administrator. The Administrator reported he knew Resident #40 fell on 5/27/2024 but had not been made aware Resident #40 had not been assessed prior to transfer back to his bed. The Administrator agreed Resident #40 should have been assessed prior to moving him from the floor to the bed.

The Administrator was made aware of Immediate Jeopardy on 6/5/2024 at 11:35 am.

The facility provided the following credible allegation of immediate jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to thoroughly assess resident #40 on 5/27/24 at 10:40 pm after he fell from his wheelchair to the floor on his left side face down. Resident #40 was discovered by his roommate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 86	F 684		

who summoned assistance from staff. Nurse #1, Nurse #2, NA #1, and NA #2 lifted resident #40 under his arms and held traction to Resident #40's left leg and picked him up from the floor and placed him in the bed. Nurse #3 completely assessed Resident #40 and observed that the left leg was internally rotated and shortened. Nurse #1 described left leg as a "limp noodle." Nurse #3 immediately summoned Emergency Medical Services (EMS) but after speaking to the Director of Nursing (DON) Nurse #3 cancelled EMS even though Resident #40 had obvious deformity that warranted a higher level of care to manage the resident's comfort needs which could not be met in the facility. On 5/28/24, Resident #40 was further assessed by the provider and sent to the emergency room.

The facility failed to identify the resident's obvious injury status post fall requiring a higher level of care.

Starting 6/6/24, the Director of Nursing (DON) will review falls within the last 30 days to ensure residents were assessed by licensed nurses identifying obvious injuries prior to being moved to determine if the resident required a higher level of care.

All the current residents with falls are at risk as a result of this deficient practice.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

On 6/10/24, the Chief Nursing Officer will educate the DON on directing the staff that call regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 87	F 684		

falls with injury to the MOST forms and when to notify family and/or EMS.

Starting 6/5/24, the Director of Nursing will educate licensed nurses on assessing resident status post falls, to include vital signs, neuro checks, range of motion, skin assessment and pain assessment, prior to being moved. Residents assessed with obvious injuries will be transferred to a higher level of care warranted by their MOST form. The Director of Nursing and clinical team will review falls daily, in clinical meetings, to ensure assessments were completed and if indicated, resident receive a higher level of care. The MOST forms will be reviewed/updated weekly and/or changes in condition by the Social Workers and kept in a binder at both nursing stations. Residents without a MOST form, Staff will notify Resident/Resident's responsible party, along with the provider, on assessment findings and guidance to determine if a higher level of care and services are warranted.

Starting 6/5/24, the Director of Nursing and the SDC will educate the licensed nurses to review resident MOST forms before calling Emergency Medical Services and if obvious deformity to include indications of fracture are observed residents should be immediately transferred to a higher level of care because resident's comfort needs cannot be met at the facility.

Starting 6/5/24, the Director of Nursing and the Staff Development Coordinator will educate all staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), licensed nurses, therapy staff, housekeeping/ laundry staff, dietary staff, social services, administrative staff, weekend staff, agency and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 88	F 684		

prn staff on ensuring that residents that experience falls are not moved prior to an assessment by a licensed nurse and reporting any changes from baseline immediately to the nurse.

Starting 6/5/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring all staff to include licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), dietary staff, social services, housekeeping/laundry staff, therapy staff, maintenance staff, administrative staff, weekend staff, agency staff and prn staff receive the education. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff. The SDC will be responsible for ensuring the education is completed.

Effective 6/5/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/12/24

A validation of immediate jeopardy removal was conducted on 06/13/24. The inital audit of falls within the last 30 days was reviewed with no issues noted and no residents that required a higher level of care identified. Nursing staff were able verbalize that they had recieved the education that after a fall, no resident was to be moved until assessed for injury by the licensed nurse. Licensed nurses were able to verbalize the steps to assessment including range of motion, vital signs, and neurological checks. They

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 89	F 684		

verbalized that if there was obvious injury that would be indicative of a fracture they were to check the MOST from, consult with the residents medial provider, as well as the residents responsible party for direction and the potential need to transfer to the acute care setting. The nursing staff were aware that the MOST forms were kept in a binder at each nursing station. Non nursing staff were able to verbalize that they had recieved education on not moving or touching a resident that had fallen but to immediately alert the licensed nurse. The education was verified to be a part of the new hire orientation packet. The immediate jeopardy removal date of 06/12/24 was validated.

2. Resident #196 was admitted to the facility on 12/18/2023 with a diagnosis of respiratory failure (condition that makes it difficult to breath independently).

A review of a care plan dated 12/18/2023 which revealed Resident #196 had an altered respiratory status and difficulty breathing related to respiratory failure with interventions which included monitoring for signs and symptoms of respiratory distress, increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy (lack of energy), confusion, hemoptysis (bloody sputum), cough, pleuritic pain (chest wall pain), accessory muscle usage, and skin color changes.

A review of the 5-day Minimum Data Set (MDS) dated 12/25/2023 revealed Resident #196 was severely cognitively impaired with no behaviors.

Review of a physician order dated 12/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 90	F 684		

read; Obtain chest-ray related to increased confusion per family members observation.

A review of a radiology report for a 2-view (from the front and from the side of the body) chest x-ray dated 12/25/2024 at 2:16 pm revealed Resident #196 had left lower airspace disease related to either pneumonia or atelectasis.

A review of the December 2023 progress notes revealed no progress note indicating a provider was made aware of the abnormal chest x-ray.

Review of a physician order dated 12/25/23 read; Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) related to increased confusion per family members observation.

A review of the December 2023 progress notes revealed no progress note indicating a provider was made aware of laboratory results or the inability to obtain laboratory results.

A review of the Resident #196's December 2023 Medication Administration Record (MAR) indicated Nurse #6 had collected a CBC and BMP on 12/25/2023 at 1:24 am.

A review of Resident #196's vital signs collected on 12/26/2023 at 10:15 am revealed a blood pressure of 147/96, heart rate of 98, a respiration rate of 16 breaths per minute, an oxygen saturation of 92%, and a temperature of 97.6 degrees Fahrenheit.

A review of a nursing assessment dated 12/26/2023 at 11:23 am revealed Resident #196 was confused, had crackles/rales (wet sounds), and pitting edema (swelling).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 91	F 684		

A review of Resident #196's vital signs collected on 12/26/2023 at 1:24 pm revealed a blood pressure of 168/89, heart rate of 102, a respiration rate of 16 breaths per minute, no oxygen saturation was obtained, and a temperature of 98.8 degrees Fahrenheit.

A review of a nursing note dated 12/26/2023 at 1:47 pm written by Nurse #5 which revealed the MD had been contacted regarding a change in Resident #196's condition and was advised to transfer Resident #196 to the hospital.

A review of a nursing note dated 12/26/2023 at 2:03 pm written by Nurse #5 revealed Resident #40 had been transferred to the hospital with Emergency Medical Services.

A review of the EMS record dated 12/26/2023 at 2:09 pm revealed Resident #196 was diagnosed with pneumonia via a chest s-ray and staff reported Resident #196 had been lethargic and not acting normally. Nursing staff reported the facility physician requested Resident #196 to be sent to the hospital. EMS documented vital signs which read; heart rate of 104, blood pressure 123/77, and an oxygen saturation of 93% on 3 liters of oxygen per minute.

A review of the Emergency Department documentation dated 12/26/2023 revealed Resident #196 had presented with altered mental status and shortness of breath. Resident #196 was admitted to the intensive care unit with acute hypoxemic respiratory failure (decreased oxygen saturation without increased carbon dioxide) and sepsis (severe infection). Resident #196 had an oxygen saturation of 83% on 6 liters of oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 92	F 684		

per minute on arrival to the Emergency Department and was placed on the BiPAP.

An interview was conducted on 6/4/2024 at 8:36 pm with Nurse #6. Nurse #6 reported she worked on 12/24/2023 during the night shift (7:00 pm to 7:00 am) and was assigned Resident #196. Nurse #6 stated after she had started her shift, Resident #196's Representative (RR) reported Resident #196 had acted more confused. Nurse #6 stated she called the provider on-call and was given orders to obtain laboratory testing and a chest x-ray. Nurse #6 reported she had not obtained laboratory testing that night because she never drew blood at night and was not able to draw blood. Nurse #6 was not able to recall documenting that she had collected Resident #196's labs, and was not sure why it was documented that she had on the MAR.

An interview was conducted on 6/4/2024 at 4:07 pm with PA #2. PA #2 reported she was notified by Nurse #6 on 12/24/2023 that Resident #196 was confused and had a cough. PA #2 reported she ordered laboratory testing and a chest x-ray. PA #2 stated she was never called about the results of the laboratory testing or chest x-ray. PA #2 reported she was not on-call 12/25/2024, and that the on-call provider that day should have been notified.

An interview was conducted on 6/4/2024 at 10:23 am with Nurse #5. Nurse #5 stated she worked 12/26/2024 and was assigned Resident #196. Nurse #5 stated she recalled Resident #196 had a chest x-ray performed that day, but she had not seen the results. Nurse #5 stated radiology reports would come over the fax machine and a Nurse or the Director of Nursing (DON) would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 684	Continued From page 93	F 684		

contact the provider on call. Nurse #5 stated she had not notified the on-call provider because she had not received the radiology report and indicated if she had received it, she would have called the provider on call. Nurse #5 reported she had not called to check the results of the chest x-ray. Nurse #5 reported she had not collected laboratory testing on Resident #196 because she was not prompted to do so on the computer system used in the facility. Nurse #5 stated she thought the labs had been completed since Nurse #6 had checked the collection off on the MAR. Nurse #5 stated when she arrived on shift 12/26/2023, she had given medications to Resident #196 and noticed he was confused but was responsive and answering questions. Nurse #5 reported she had checked on him hourly. Nurse #5 stated around lunchtime (11:30 am) she noticed Resident #196 had pitting edema (swelling), crackles (wet lung sounds), and was only responsive to painful stimuli. Nurse #5 stated Resident #196 continued to wear oxygen at 3 liters per minute. Nurse #5 reported she notified the physician, at the time documented in the Electronic Health Record (EHR), 1:47 pm and received an order to send Resident #196 to the Emergency Department. Nurse #5 was unsure why there was an approximately 2-hour delay in her notification to the MD and she obtained one set of vital signs prior to transfer and was unable to recall if she obtained an oxygen saturation or not. Nurse #5 reported she transferred Resident #196 to the Emergency Department via Emergency Medical Services (EMS) at 2:04 pm.

An interview was conducted on 6/4/2024 at 8:36 pm with Nurse #7. Nurse #7 stated she worked on 12/25/2024 on night shift (7:00 pm to 7:00 am). Nurse #7 was assigned Resident #196 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 94	F 684		

was not able to recall receiving chest x-ray results during her shift and had not called to check on them. Nurse #7 stated if she received it she would called the on call provider with the results. Nurse #7 stated she would assume dayshift had notified the provider since it had resulted during dayshift. Nurse #7 reported she drew blood at night if it was ordered but was not able to recall Resident #196.

An interview was conducted on 6/5/2024 at 3:32 pm with the MD. The MD reported she had been contacted by Nurse #5 on 12/26/2023 at 1:47 pm that Resident #196 had a change in condition and was less responsive. The MD stated Nurse #5 had not informed her Resident #196 was only responsive to painful stimuli at 11:23 am on 12/26/2023. The MD stated she would expect Nurses to notify the MD as soon as possible with mental status changes.

An interview was conducted on 6/7/2024 at 8:37 am with the Director of Nursing (DON). The DON stated abnormal radiology results were faxed to the facility. The DON stated Nurses checked the fax machine routinely for results and were to notify the on-call provider of any results. The DON also reported she obtained results from labs and radiology every morning and notified the provider as well. The DON confirmed there was no indication in Resident #196's medical record that the on-call provider had been notified of the x-ray or that nursing staff had called to check on the results of the chest x-ray. The DON stated she assumed it was because the report was not marked as "alert" which would usually indicated to staff the provider should be contacted. The DON reported laboratory tests were to be drawn and sent out. She stated the facility utilized an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 684	Continued From page 95 outside phlebotomist, but that Nurses could draw labs and use the courier until a certain time. The DON stated after the courier hours were over, if the resident had labs that needed to be drawn immediately, they would need to be sent to the hospital. The DON stated if the labs were not emergent, the phlebotomist would draw them the next morning. The DON was not aware Resident #196's labs had not been collected by Nurse #6 and that the provider was not made aware the labs had not been collected. The DON stated the on-call provider should have been notified of new laboratory results or the inability to obtain laboratory results. The DON stated nurses were expected to report changes in condition to the provider on the phone immediately. The DON was not aware there had been an approximate 2-hour delay in notifying the provider that Resident #196 was only responsive to painful stimuli, and stated Nurse #5 should have notified the provider immediately.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and Resident interviews, the facility failed to ensure physical therapy had established a safe means for nursing to transfer a resident prior to a resident (Resident	F 689	Resident #346 was discharged from the facility on 7/8/2023. Resident #62 safe smoking assessment was updated on 6/11/24 by social	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 689	Continued From page 96 #346) falling. The facility also failed to complete quarterly safe smoking assessments on a resident (Resident #62) for 2 of 7 reviewed for accidents. The findings included: 1. Resident #346 was admitted to the facility on 6/29/2023 with diagnoses which included anxiety, post-traumatic stress disorder, and major depressive disorder. Review of a physical therapy (PT) evaluation dated 6/30/2023 written by PT #1 revealed Resident #346 was dependent for chair/bed-to chair transfers. Review of a PT treatment noted dated 7/6/2023 written by PT #2 revealed Resident #346 had been assisted by PT with a transfer from the wheelchair to the shower chair using the slide board, at which time he required maximum assistance with set-up and transfer. A review of an admission Minimum Data Set (MDS) dated 7/6/2023 revealed Resident #346 was cognitively intact. Documentation revealed Resident #346 was coded as having physical behavioral symptoms directed towards others, verbal behavior symptoms directed towards others, and other behavioral symptoms not directed towards others. The behaviors were coded as putting Resident #346 at significant risk for physical illness or injury, interfering with Resident #346's care, and interfering with Resident #346's participation in activities and social interactions. Resident #346 was coded as placing others at risk of physical injury. Resident #346 was coded as dependent for toileting,	F 689	services. The current residents that use slide boards for transfers and/or smoke or are at risk for this deficient practice. Social Services will complete audits of residents that smoke by 7/16/24 to ensure smoking assessments are being updated quarterly. Therapy will complete audits of residents that require slide board assistance for transfer by 7/16/24 to ensure the nursing staff have been trained on using the slide boards for transfers. The Director of Nursing will educate social services by 7/16/24 on ensuring smoking assessments are being completed quarterly. New hire social services will not be allowed to work until the education is completed. Therapy will education the nursing staff by 7/16/24, to include licensed nurses, certified medication aides (CMA), and certified nursing assistants (CNA) on ensuring staff has been trained on a safe means of transfer to include the slide board, prior to transferring residents. New hire nursing staff and prn staff will not be allowed to work until the education is completed. Social Services will complete audits weekly x 4 weeks and monthly x 2 months of residents that smoke to ensure smoking assessments are being completed quarterly. Social Services will report the findings to the Quality Assurance Improvement Performance (QAPI) committee for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 689	Continued From page 97	F 689		

bathing/showering, substantial/maximal assistance with lower body dressing and putting on/taking off footwear.

Review of a care plan dated 7/6/2023 revealed Resident #346 required extensive assistance of 1 to 2 people for transfers, and Resident #346 had not been care planned for the use of a slide board.

Review of an incident report dated 7/6/2023 at 12:45 pm written by Nurse #13 revealed Resident #346 had fallen off the slide board during a transfer from the bed to the wheelchair while being assisted by NA #9. A head-to-toe assessment was completed, Resident #346 had no complaints of pain and was assisted back to the wheelchair. PA #1 was notified, and an x-ray was ordered. Therapy was notified to educate resident on foot/body positioning when transferring using a slide board.

Review of a PT treatment note dated 7/7/2023 written by the PT Director revealed Resident #346 had been educated on safe sequencing by having both feet placed flat on the floor.

An interview was conducted on 6/6/2024 at 11:01 am with Nurse #13. Nurse #13 reported she was unable to remember Resident #346, his fall on 7/6/2023, or completing an incident report.

An interview was conducted on 6/6/24 at 12:37 am with NA #9. NA #9 reported she had worked on 7/6/2023 and was assigned Resident #346. NA #9 reported she was only able to remember transferring him with a slide board and recalled him sliding off the slide board. NA #9 reported Resident #346's feet were not placed flat on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 689	Continued From page 98	F 689		

ground, and she had attempted to que him to flatten his feet but reported Resident #346 "kept moving" and slid onto the floor. NA #9 reported she had not been trained on how to use a slide board specifically with Resident #346, but had found the slide board in his room, and had been told by an NA in report that Resident #346 used a slide board with transfers.

An interview was conducted on 6/6/2024 at 10:30 am with the PT Director. The PT director was able to recall working with Resident #346. He reported nursing staff were required to be trained on how to use a slide board with each resident specifically prior to using it. The PT Director confirmed nursing staff had not been educated about how to transfer Resident #346 using a slide board because PT staff had not felt like nursing staff could safely transfer him using one because of his impulsive behavior. The PT Director was not sure why a slide board was left at the bedside since the nursing staff had not been cleared to use it with Resident #346. The PT Director felt that nursing should have used a mechanical lift until Resident #346 was proven safe with a slide board.

An interview with PT #1 was attempted on 6/6/2024 and was unsuccessful.

An interview with PT #2 was attempted on 6/6/2024 and was unsuccessful.

An interview was conducted on 6/7/2024 at 8:44 am with the Director of Nursing (DON). The DON reported therapy was required to educate nursing staff and clear a resident to use a slide board prior to nursing staff utilizing one. The DON reported each resident required different

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 689	Continued From page 99	F 689		

techniques for transferring with a slide board and therapy educated nursing staff on how to use one for each resident. The DON was not aware NA #9 had not been educated regarding using a slide board with Resident #346 and reported she should have had education by PT prior to using one.

An interview was conducted on 6/7/2024 at 3:25 pm with the Administrator. The Administrator reported he was not employed at the facility at the time of the incident but was surprised a slide board was left in the room if nursing staff had not been cleared to use it with the resident. The Administrator expected staff to be trained on the use of a slide board.

2. Resident #62 was admitted to the facility on 01/27/23 with diagnoses that included cerebral vascular accident (CVA), hemiplegia and dementia.

A review of Resident #62's medical record revealed the last safe smoking screening dated 03/31/23 revealed the Resident was able to smoke independently. The screen was completed by SW #1.

A review of Resident #62's annual Minimum Data Set (MDS) assessment dated 02/04/24 revealed the Resident's cognition was moderately impaired and he used tobacco.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 689	Continued From page 100 An interview was conducted with Resident #62 on 06/04/24 at 9:12 AM. The Resident indicated that he smoked independently when he chose to smoke and kept his smoking materials in his locker. During interviews with Social Worker (SW) #1 on 06/04/24 at 4:24 PM and 06/07/24 at 9:11 AM, the SW explained that the safe smoking screenings were completed on admission and quarterly and as changes indicated by social services or nursing. The screens automatically popped up under the assessments to be done. She continued to explain that she assessed the residents while they demonstrated smoking and completed the questionnaire to determine if they were a safe smoker and Resident #62 was determined to be a safe smoker. The SW acknowledged that Resident #62's safe smoking screen was last completed on 03/31/23 by herself and when asked why a safe smoking screen had not been completed since 03/31/23 the SW stated, "I do not know how that fell through the cracks." An interview conducted with the Director of Nursing on 06/07/24 at 10:03 AM revealed the safe smoking screening should be done quarterly along with the MDS assessments and as needed by social services or the nursing staff.	F 689		
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 admission receives services and assistance to	F 690		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 690	Continued From page 101 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, resident, and staff interview the facility failed to secure an indwelling catheter to prevent displacement and/or tension for 1 of 1 resident reviewed with a catheter (Resident #39). The findings included:	F 690	Resident #39 catheter was anchored to the thigh by Nurse #17 on 6/7/24. Residents with indwelling catheters are at risk for this deficient practice. The Director of Nursing will complete an audit of residents with indwelling to ensure catheters are being anchored to prevent	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 690	Continued From page 102 Resident #39 was admitted to the facility on 02/01/23 and most recently readmitted on 01/04/24. Resident #39's diagnosis included retention of urine. A care plan revised on 01/14/24 read, Resident #39 has an indwelling catheter related to urinary retention and wound. The interventions included: monitor and document intake as per facility policy, monitor for signs and symptoms of discomfort on urination and frequency, monitor/document pain/discomfort due to catheter, monitor and report to Medical Doctor for signs and symptoms or urinary tract infection, and provide catheter care every shift. A quarterly Minimum Data Set (MDS) dated 04/14/24 revealed that Resident #39 was cognitively intact and had an indwelling catheter during the assessment reference period. An observation of Resident #39 was made on 06/03/24 at 11:58 AM. Resident #39 was resting in bed. She was noted to have an indwelling catheter and the tubing was not anchored and was resting on the bed under her leg. There was a collection bag hanging from the side of the bed with approximately 200 milliliters (ml) of clear yellow fluid in the bag which was covered with a privacy cover. An observation of Resident #39 was made on 06/04/24 at 3:21 PM. Resident #39 was resting in bed on her right side. Her indwelling catheter tubing was resting on her left thigh but was not anchored or secured, the collection bag was hanging from the side of the bed and contained a privacy cover.	F 690	them from being pulled or tugged by 7/16/24. The Director of Nursing/Unit Manager will educate the nursing staff to include the licensed nurses, certified medication aides (CMA), certified nursing assistants, agency, weekend, and prn staff to ensure indwelling catheters are being anchored and/or secured to residents' thigh to prevent pulling. CNAs and CMAs should notify the licensed nurse if resident catheter is observed to not be secured. Staff to include new hires and prn staff who have not completed this education by 7/16/24 will not be allowed to work until the education is completed. The Director of Nursing will complete audits weekly x 4 weeks and monthly x 2 months to ensure indwelling catheter continue to be anchored to prevent pulling. The Director of Nursing will submit the findings to the monthly Quality Assurance Improvement Performance (QAPI) committee for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 690	Continued From page 103	F 690		

An observation of Resident #39 was made on 06/05/24 at 2:54 PM. Resident #39 was resting in bed and again her indwelling catheter was not anchored or secured to either leg.

An observation and interview were conducted with Resident #39 on 06/07/24 at 11:32 PM. Resident #39 was resting in bed and her indwelling catheter was not anchored or secured to eighter leg. Her collection bag was hanging from the side of the bed with a privacy cover in place. Resident #39 stated that the facility staff did not normally anchor or secure the tubing to her leg and that sometimes it pulled and tugged and cause her some discomfort. And added if they did come to anchor it or secure it they "are going to put it on top" of her leg because it hurts when it was placed under her leg.

Nurse Aide (NA) #11 was interviewed on 06/07/24 at 11:34 Am. NA #11 confirmed that she was caring for Resident #39 and stated that had not yet provided care to her. She stated that Resident #39 rang her call light when she was ready to get cleaned up for the day. NA #11 stated that she cleaned her catheter and emptied her catheter bag several times throughout her shift. She added that the nurses were responsible for putting the anchor on the residents but if she saw that it was not there would let the nurse know and she would ensure the anchor got put in place. NA #11 was requested to check Resident #39's indwelling catheter and confirmed that it was not anchored to her upper leg and that she would alert the nurse because she had not so yet.

Nurse #17 was interviewed on 06/07/24 at 11:39 AM. She stated that the NAs should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 690	Continued From page 104 monitoring that each indwelling catheter tubing was anchored and if not make the nurse aware so it can be replaced or put into place. Nurse #17 stated that no one had reported to her that Resident #39 did not have an anchor for her indwelling catheter but stated she would take care of it promptly. Medication Aide (MA) #1 was interviewed on 06/07/24 at 12:08 PM. MA #1 confirmed that she had been on the medication cart on Resident #39's unit on 06/03/24, 06/04/24, and 06/07/24 and no one had reported to her that Resident #39 did not have an indwelling catheter anchor. She stated she "did nothing with the anchors" the nurses would take care of that, however if one of the NAs reported to her that a resident needed one, she would report that information to the nurse. The Director of Nursing (DON) was interviewed on 06/07/24 at 12:34 PM. She stated that the NAs should clean the catheter twice a day and each indwelling catheter should be anchored or secured to the resident's leg to prevent tension and displacement. The placement of the anchor should be checked every shift by the nursing staff and replaced as needed or if soiled or missing.	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 695	Continued From page 105 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure a resident was administered oxygen per physician order, failed to clean oxygen concentrators, and failed to post cautionary and safety signs that indicated oxygen was in use for 3 of 3 residents reviewed for respiratory care (Residents #34, #40 and #45). The findings included: 1. Resident #40 was admitted to the facility on 5/19/2018 with a diagnosis of chronic obstructive pulmonary disorder (COPD, chronic inflammation of the lungs leading to an obstruction of airflow to the lungs). A quarterly Minimum Data Set (MDS) dated 5/8/2024 revealed Resident #40 was severely cognitively impaired. Resident #40 was documented as receiving oxygen therapy. a. A review of a physician's order dated 2/14/2023 revealed Resident #40 was ordered oxygen to be delivered at 2 liters/minute continuously. A review of the physician's orders dated 6/15/2023 revealed Resident #40 was to have vital signs checked every Thursday during day shift. A review of the care plan dated 5/8/2024 revealed Resident #40 was at risk for ineffective breathing patterns due to a diagnosis of COPD with interventions which included administering	F 695	On 6/5/24, Nurse #10 reapplied resident #40 oxygen at 2L per nasal canula and rechecked oxygen levels at 92%. Resident #40 was seen by the provider on 6/6/24 with no new orders. Resident remains at baseline. Resident #45 was seen by the provider on 6/12/24 with no new orders. Resident remains at baseline. Resident #34 was seen by the provider on 6/6/24 and 6/15/24 with no new orders. Resident remains at baseline. Residents that require oxygen are at risk for this deficient practice. Resident #34, Resident #40, Resident #45 concentrators, tubing and filters checked by the Unit Manager on 6/27/2024. Resident #34 tubing was changed. Oxygen signage posted outside of Resident #34, #40, #45 doors. The Unit Manager completed an audit of residents with oxygen to ensure oxygen is in place as ordered, oxygen signage on doors, oxygen concentrators clean, filters clean, and tubing dated and changed weekly on 6/27/2024. 1 resident required oxygen signage, 5 oxygen tubings needed to be changed, 4 oxygen filters needed to be cleaned, and 5 concentrators needed to be cleaned. The Unit Manager/ Director of Nursing will complete education with the licensed nurses to include agency, prn, and weekend nurses on ensuring residents are receiving oxygen as ordered, oxygen	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 695	Continued From page 106 oxygen per order. Resident #40 was not documented for a history of removing oxygen or any behaviors. A review of the May 2023 vital signs records revealed Resident #40's last oxygen saturation had been checked on 5/30/2024, which read: 94%. There was no indication of oxygen usage when the oxygen saturation was obtained. An observation was conducted on 6/3/2024 at 10:59 am. Resident #40 was observed without oxygen on. Resident #40's nasal canula was draped over his nightstand, out of his reach. Resident #40's oxygen concentrator was observed to be white with dust. An observation was conducted on 6/4/2024 at 8:51 am. Resident #40 was observed without oxygen on. Resident #40's nasal canula was draped over his nightstand, out of his reach. An observation was conducted on 6/5/2024 at 2:27 pm. Resident #40 was observed without oxygen on. Resident #40's nasal canula was draped over his nightstand, out of his reach. An observation was conducted on 6/6/2024 at 9:16 am. Resident #40 was observed to have his oxygen on, and his oxygen concentrator set to deliver at 2 liters per minute. An observation was conducted on 6/6/2024 at 10:58 am. Resident #40 was observed wearing his oxygen at 2 liters per minute. 1b. An observation was conducted on 6/4/2024 at 8:51 am. Resident #40's oxygen concentrator was observed to be white with dust.	F 695	signage is posted outside resident's room, concentrations cleaned, filters cleaned and tubing is being changed at least weekly and prn. Licensed nurses will not be allowed to work after 7/16/24 until this education is completed. New hires and prn staff will not be allowed to work without completing this education. The Director of Nurses will complete audits weekly x 12 weeks and monthly x 1 month to ensure residents are receiving oxygen as orders, signage is posted outside resident rooms, oxygen concentrators and filters are being cleaned and oxygen tubing is being changed. The Director of Nursing will report findings to the Quality Assurance Improvement Performance (QAPI) committee for review and/revision to ensure continual compliance.	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 695	Continued From page 107	F 695		

An observation was conducted on 6/5/2024 at 2:27 pm. Resident #40's oxygen concentrator was observed to be white with dust.

An observation was conducted on 6/6/2024 at 9:16 am. Resident #40's oxygen concentrator's external filter was noted to be white with dust.

An observation was conducted on 6/6/2024 at 10:58 am. Resident #40's oxygen concentrator external filter was observed to be clean and free of dust.

An interview was conducted on 6/5/2024 at 3:49 pm with Nurse #10. Nurse #10 reported if a resident was ordered oxygen, there would be an order in the Electronic Health Record (EHR), and oxygen would be listed on the MAR. Nurse #10 verified Resident #40 was ordered continuous oxygen. Nurse #10 reported she checked oxygen saturations every shift, before/after breathing treatments, and on an as needed basis. Nurse #10 stated oxygen concentrator filters were supposed to be cleaned and oxygen tubing was supposed to be changed weekly on night shift or as needed. Nurse #10 verified Resident #40 had an order for oxygen to be delivered at 2 liters/per minute continuously. Nurse #10 was asked to observe Resident #40 and agreed he was not wearing oxygen and should have been. Nurse #10 noted his oxygen tubing draped over his nightstand out of his reach and stated she was not sure why it was laying there. Nurse #10 stated Resident #40 had not had a history of removing his oxygen and would usually leave it in place. Nurse #10 checked Resident #40's oxygen saturation level on his right index finger and noted the result to be 89%. Nurse #10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 695	Continued From page 108	F 695		

immediately placed Resident #40 on 2 liters of oxygen, and his oxygen saturation rose to 92%. Nurse #10 was asked to observe the oxygen concentrator filter and agreed the external filter was white with dust and needed to be cleaned. Nurse #10 stated the external filter should have been cleaned on night shift and reported she would clean it.

An interview was conducted on 6/6/2024 at 9:19 am with Nurse #11. Nurse #11 stated if a resident was supposed to wear oxygen there would be an order for oxygen in the EHR and would be on the MAR as well. Nurse #11 verified oxygen was on Resident #40's MAR. Nurse #11 stated she was unsure who was responsible for cleaning oxygen concentrator filters and reported she assumed it was maintenance. Nurse #11 reported oxygen tubing was changed weekly. Nurse #11 was asked to observe Resident #40's oxygen concentrator filter, and agreed it was white with dust. Nurse #11 stated she would clean Resident #40's filter.

An interview was conducted on 6/6/2024 at 12:30 pm with the Unit Manager (UM). The UM reported if a resident was ordered oxygen, they should be wearing it. The UM stated night shift nurses were responsible for cleaning oxygen concentrator filters and changing oxygen tubing weekly or on an as needed basis. The UM reported she had not been monitoring to ensure staff had cleaned filters and changed tubing. The UM stated Nurses were to monitor that it was done. The UM was not aware Resident #40 had, had a dusty oxygen concentrator external filter and reported it should have been cleaned on night shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 695	Continued From page 109	F 695		

An interview was conducted on 6/6/2024 at 8:39 am with the Director of Nursing (DON). The DON stated if a resident was supposed to be wearing oxygen it would show up on the MAR. The DON stated if a resident was ordered oxygen they should be wearing and there were orders in the Electronic Health Record and MAR for continuous oxygen to be administered at 2 liters per minute via nasal canula. The DON stated if the resident was able to remove their own oxygen, it should be care planned for that behavior. The DON stated oxygen concentrator external filters and tubing were to be changed on Wednesdays by night shift Nurses. The DON was not aware Resident #40 had not worn his oxygen on 6/3/2024, 6/4/2024, and part of the shift on 6/5/2024 and verified he should have been. The DON stated Resident #40 was not care planned or known for removing his own oxygen. The DON was also not aware Resident #40's external filter on his concentrator had been dusty, and agreed it should have been cleaned when it was observed.

An interview was conducted on 6/7/2024 at 3:24 pm with the Administrator. The Administrator stated he was unsure when oxygen concentrator filters should be cleaned but that he was looking into it and was going to add it to their Quality Assurance (QA). The Administrator agreed oxygen should be administered per order. The Administrator was not aware Resident #40 had not worn his oxygen and had a dusty external filter on his oxygen concentrator.

2. Resident #45 was admitted to the facility on 8/21/2023 with a diagnosis of chronic respiratory failure and Chronic Obstructive Pulmonary Disorder (COPD, chronic inflammation of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 695	Continued From page 110	F 695		

lungs leading to an obstruction of airflow to the lungs).

A review of a physician's order dated 4/1/2024 revealed Resident #45 was ordered oxygen to be administered at 2 liters per minute via nasal canula continuously.

A review of a quarterly Minimum Data Set (MDS) dated 4/5/2024 revealed Resident #45 was cognitively intact with no behaviors. Resident #45 was documented as receiving oxygen therapy.

A review of a care plan dated 4/5/2024 revealed Resident #45 had respiratory failure with interventions which included administering oxygen at 2 liters per minute.

An observation was conducted on 6/3/2024 at 11:15 am. Resident #45 was observed lying in bed wearing oxygen in her nose. Resident #45's oxygen concentrator was set to deliver oxygen at 2 liters per minute. There was no oxygen signage outside of Resident #45's room indicating she was on oxygen.

An observation was conducted on 6/4/2024 at 2:49 pm. Resident #45 was observed lying in bed wearing oxygen in her nose. Resident #45's oxygen concentrator was set to deliver oxygen at 2 liters per minute. There was no oxygen signage outside of Resident #45's room indicating she was on oxygen.

An observation was conducted on 6/5/2024 at 2:25 pm. Resident #45 was sitting in a wheelchair beside her bed, wearing oxygen in her nose. Resident #45's oxygen concentrator was set to deliver oxygen at 2 liters per minute. There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 695	Continued From page 111	F 695		

was no oxygen signage outside of Resident #45's room indicating she was on oxygen.

An interview was conducted on 6/5/2024 at 2:40 pm with Nurse #12. Nurse #12 stated she was assigned Resident #45 and verified she was ordered to wear oxygen at 2 liters per minute. Nurse #12 reported she was unsure if signage had to be placed outside of a room where oxygen was in use. Resident #12 verified there was no oxygen signage outside of Resident #45's room.

An interview was conducted on 6/7/2024 at 8:39 am with the Director of Nursing (DON). The DON stated if a resident was wearing oxygen there should be signage outside of their room placed by the nurse upon admission. The DON was not aware there had not been oxygen signage outside of Resident #45's room and stated there should have been.

An interview was conducted on 6/7/2024 at 3:24 pm with the Administrator. The Administrator was not aware Resident #45's room did not have signage indicating oxygen was in use and agreed there should have been a sign on the door.

3. Review of Resident #34's care plan dated 01/08/24 revealed the Resident has oxygen therapy related to respiratory therapy. The goal that Resident #34 will have no signs or symptoms of poor oxygenation will be attained by providing oxygen via nasal cannula.

Resident #34 was readmitted to the facility on 04/01/24 with diagnoses that included chronic respiratory failure.

The quarterly Minimum Data Assessment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 695	Continued From page 112	F 695		

04/04/24 revealed Resident #34 was cognitively intact and required oxygen.

A review of Resident #34's physician order dated 04/01/24 for oxygen to be delivered at 4 liters per minute via nasal cannula. There was also an order to rinse or replace oxygen filters weekly and as needed on Wednesday nights.

A review of Resident #34's 05/2024 Treatment Administration Record (TAR) revealed the order for the oxygen filters to be rinsed or replaced weekly on Wednesday night was initialed as being completed. The 06/2024 TAR revealed the order for the oxygen filters to be rinsed or replaced weekly on Wednesday nights was initialed on 06/05/24 as being completed by Nurse #15.

On 06/03/24 at 11:03 AM an observation was made of Resident #34 wearing supplemental oxygen via nasal cannula. The oxygen concentrator had bilateral black external filters on the concentrator that were dusty and appeared gray. Also, there was no cautionary sign posted on the Resident's door to indicate oxygen was in use.

Subsequent observations of Resident #34's oxygen concentrator filters and door on 06/04/24 at 10:29 AM and 06/05/24 at 2:29 PM revealed the filters remained dusty and there was no signage posted on the door.

On 06/05/24 at 3:57 PM an interview was conducted with Nurse #12 who was the Nurse on duty. The Nurse acknowledged the dirty filters and stated, "oh my goodness, they are dirty." The Nurse explained that she had only been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 695	Continued From page 113 employed a short time at the facility and did not know the policy for the oxygen filters. She also stated the admitting nurse should have posted the oxygen sign on the Resident's door. An observation was made on 06/06/24 at 10:11 AM of Resident #34's oxygen concentrator filters. The filters remained dusty gray. An interview was conducted with Nurse #15 on 06/06/24 at 10:54 AM who acknowledged he took care of Resident #34 on the night of 06/05/24. The Nurse stated that he got busy and did not get to check the filters on the Resident's concentrator. During an interview with the Director of Nursing (DON) on 06/07/24 at 9:46 AM the DON explained the oxygen concentrator filters should be cleaned once a week on Wednesday third shift and as needed in case they need cleaning more than weekly. She stated the admitting nurse should place the oxygen in use sign on the residents' door when they were admitted. The DON stated Resident #34 had changed rooms recently and the nurses must have missed moving the oxygen sign to her new room.	F 695		
F 697 SS=J	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 114 Based on observations, record review, staff, Physician Assistant (PA), and Medical Director (MD) interviews the facility failed to provide effective pain management for a resident (Resident #40) after a fall, with obvious deformity, or transfer him to the hospital for pain that could not be managed in the facility as outlined by his advanced directive. On 5/27/2024 Resident #40 was found face down on the floor beside his bed and was noted to have internal rotation and shortening of the left hip and leg. Resident #40 was crying, moaning, guarding (protecting/holding) his left leg, grimacing, and unable to be consoled by staff. Nurse #3 immediately summoned Emergency Medical Services (EMS) but after review of the resident's chart and speaking to the Director of Nursing (DON), she was instructed to cancel EMS because Resident #40 had an advance directed that indicated "Do Not Hospitalize" unless his comfort needs could not be met at the facility. Nurse #3 notified the provider on-call and obtained an order for a one-time dose of Ibuprofen (pain medication, decreases inflammation) to be given for pain and a left hip/pelvis x-ray. Nurse #3 administered that medication as well as oxycodone-acetaminophen 5-325 mg (pain medication) that was scheduled (for every 6 hours) at 12:00 am and Resident #40 continued to grimace in pain throughout the remainder of her shift. Nurse #3 administered the 6:00 am oxycodone-acetaminophen. Nurse #10 administered oxycodone-acetaminophen 5-325 mg tablet on 5/28/2024 at 12:19 pm, and documented a pain assessment of 8 out of 10 for Resident #40. An x-ray was performed in the facility on 5/28/2024 which revealed Resident #40 had sustained an acute fracture of the proximal left femur (thigh bone) and Resident #40 was	F 697	The facility failed to address Resident #40□s pain to his left hip after sustaining a fall from his wheelchair which resulted in an acute fracture of the proximal femur. On 6/12/24, the Director of Nursing and the licensed nurses completed new pain assessments of the current residents to include review of progress notes, care plans and resident pain regiments to ensure resident pain is being managed and/or prevented. Interviewable residents were also interviewed by the licensed nurse to ensure that their current pain regime is adequate. 2 interviewable residents reported some concerns with pain. Both residents are being seen and/or followed up at the outside Pain Clinic. All the current residents are at risk as a result of this deficient practice. On 6/10/24, the Chief Nursing Officer reviewed the Maple Health Pain Management Prevention Plan to include non pharmacological interventions with the Director of Nursing. Starting 6/5/24, Director of Nursing, Unit Manager and the Staff Development Coordinator will educate the licensed nurses, certified nursing assistants (CNA), and the certified medication aides (CMA) on identifying signs and symptoms of pain, non pharmacological pain interventions and pain management and prevention to include follow up with the provider if pain management interventions are not effective. Pain will be assessed every shift, after a fall, with changes in	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 115 transferred to the hospital on 5/28/2024 where he was admitted for further evaluation and pain management. The deficient practice occurred for 1 of 3 residents (Resident #40) reviewed for pain management. Immediate jeopardy began on 5/27/2024 when Resident #40 had fallen and was noted to have an obvious deformity and was not immediately transferred to the acute care hospital to ensure effective pain management. Immediate jeopardy was removed on 6/10/2024 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #40 was admitted to the facility on 5/19/2018. His recent diagnosis as of January 2024 included a dislocation of the internal left hip. Resident #40 was documented as deaf and mute. Review of a Medical Order for Scope of Treatment dated 7/13/2023 completed by PA #1 revealed Resident #40 did not want to be resuscitated if he had no pulse and was not breathing. The MOST form stated Resident #40 wanted comfort measures to include "keep clean, warm dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort." Resident #40 was not to be transferred to the hospital unless comfort needs	F 697	condition and before and after pain medication administration and documented in the medication administration record or the progress notes. Starting 6/5/24, the Unit Manager and the Director of Nursing will be responsible for ensuring licensed nurses, weekend nursing staff, CNAs, and CMAs receive the education to include identifying sign and symptoms of pain, non pharmacological pain interventions, and pain management and prevention to include follow up with the provider if pain management interventions are not effective. Staff including new hires and prn staff and agency staff will not be allowed to work after 7/16/24 without completing this education. The education will be ongoing to include new hires and prn staff. The Director of Nursing will be responsible for ensuring the education is completed. The Director of Nursing will review residents with falls 2 x weekly for 4 weeks and monthly for 2 months to ensure residents have been assessed for pain and changes in condition. The Director of Nursing will report the findings to the Quality Assurance Improvement Performance committee for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 116	F 697		

could not be met in the facility.

A review of physician's orders dated 1/17/2024 revealed Resident #40 was ordered oxycodone-acetaminophen 5-325 milligrams (mg) scheduled every 6 hours.

A quarterly Minimum Data Set (MDS) dated 5/8/2024 revealed Resident #40 was severely cognitively impaired. Resident #40 was documented as receiving opioids (pain medication). The pain management section of the MDS revealed Resident #40 had a scheduled pain medication regimen, he had not received any as needed pain medications, had not received any non-medication intervention for pain, and had not had any pain in the last 5 days.

The care plan dated 5/8/2024 revealed Resident #40 required partial to moderate assistance with transfers. Resident #40 was care planned for chronic pain and risk for pain with interventions which included to evaluate the effectiveness of pain interventions.

The pain documentation, on the MAR, from 5/1/2024 through 5/26/2024 revealed Resident #40 had a pain scale of 0 out of 10, when checked during the day and night shift), every day.

Review of the MAR from 5/1/2024 through 5/26/2024 revealed documentation for administration of oxycodone-acetaminophen 5-325 mg every 6 hours (12:00 am, 6:00 am, 12:00 pm, and 6:00 pm) as scheduled for Resident #40.

An incident report dated 5/27/2024 completed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 117	F 697		

Nurse #3 revealed Resident #40 was found at 10:40 pm lying face down on the floor beside the bed. An assessment revealed Resident #40 had internal rotation and shortening of the left leg, a small head laceration to the top of the scalp, and a small laceration to the left outer ankle. Nurse #3 documented Resident #40 to be unconsolable, rigid with clenched fists, moaning, groaning, and had facial grimacing.

A nursing note dated 5/27/2024 at 10:40 pm written by Nurse #3 revealed Resident #40 was found lying face down on the floor beside his bed. An assessment revealed Resident #40 had internal rotation and shortening of the left leg, pain when moving/repositioning his leg, small head laceration on the left side of his forehead, and a small laceration on his left ankle. Resident #40 was assessed, and vital signs taken. Resident #40 complained of pain in his left hip.

Resident #40's physician's orders dated 5/27/2024 written by the MD revealed an order for Ibuprofen (pain medication, decreases inflammation) 600 mg to be administered by mouth one time only for pain.

The May 2024 Medication Administration Record (MAR) revealed the following:

Nurse #3 documented that she administered Ibuprofen 600 mg to Resident #40 on 5/27/2024 at 11:15 pm and oxycodone-acetaminophen 5-325 mg tablet (which lasts 6 hours) on 5/28/2024 at 12:00 am, as scheduled, and had not documented a pain assessment for Resident #40 or re-evaluated the pain medication's effectiveness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 118	F 697		

Nurse #3 documented that she administered oxycodone-acetaminophen 5-325 mg tablet again at 6:00 am, as scheduled, and had not documented a pain assessment for Resident #40 or re-evaluated the pain medication's effectiveness.

A nursing note dated 5/28/2024 at 5:24 am written by Nurse #3 revealed PA #2 had been contacted to inform PA #2 that Resident #40 had a low blood pressure.

An interview was conducted on 6/4/2024 at 12:38 pm written by Nurse #3. Nurse #3 reported she was passing medications on 300 hall on 5/27/2024, and was assigned Resident #40, when Nurse Aide (NA) #1 and NA #2 came to tell her that Resident #40 was laying in the floor by the bed. Nurse #3 reported she observed Resident #40's left leg to be internally rotated and shorter than his right leg. Nurse #3 stated she contacted the on-call provider, PA #2, and informed her Resident #40 had fallen, that she had observed internal rotation and shortening of his left leg, and that he was experiencing a lot of pain, at which time PA #2 ordered Ibuprofen 600 milligrams (mg) one time for pain. Nurse #3 verified Resident #40 was crying, rigid with clenched fists, moaning/groaning, and had facial grimacing. Nurse #3 stated she administered Ibuprofen 600 mg in addition to his scheduled pain medication (oxycodone-acetaminophen) that he already had ordered. Nurse #3 reported the NAs had told her Resident #40 experienced excessive pain, continued to moan anytime his leg was touched, guarded, and was unable to consoled throughout the night. Nurse #3 stated she had contacted PA #2 again on 5/28/2024 at 5:30 am to inform her of a low blood pressure but failed to notify her that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 119	F 697		

Resident #40 was still in pain. Nurse #3 stated she had forgotten to mention it because she was more worried about Resident #40's blood pressure being too low. Nurse #3 reported she had not administered any additional pain medication, except another scheduled dose of oxycodone-acetaminophen 5-325 mg at 6:00 am.

PA #2 was unavailable for an interview.

An interview was conducted on 6/4/2024 at 7:26 pm with NA #2. NA #2 reported she worked night shift (7:00 pm to 7:00 am) on 5/27/2024 and was assigned 400 hall. NA #2 stated Resident #40 moaned, grimaced, and guarded his left leg anytime he was moved or repositioned throughout the night when she assisted with him, and that Nurse #3 was notified about his pain. NA #2 reported staff checked on Resident #40 at least every 2 hours.

An interview was conducted on 6/4/2024 at 7:57 pm with NA #1. NA #1 reported she worked night shift (7:00 pm to 7:00 am) on 5/27/2024 and was assigned 200 and 400 halls. NA #1 reported during the transfer Resident #40 was crying during transfer and when NA #2 would help her turn and reposition Resident #40 throughout the remainder of the shift. NA #1 stated she was hesitant to reposition Resident #40 throughout the night because he was exhibiting nonverbal grimacing, moaning, and guarding of his left leg.

The pain documentation, on the MAR, from 5/27/2024 through 5/28/2024 revealed Resident #40 experienced pain 6 out of 10 during day shift on 5/28/2024, with no time noted, and 8 out of 10 on 5/28/2024 at 12:19 pm prior to being transferred to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 120	F 697		

An interview was conducted on 6/4/2024 at 4:51 pm with Nurse #1. Nurse #1 reported she worked night shift (7:00 pm to 7:00 am) on 5/27/2024 on 400 hall and was passing medications when she heard Resident #44 yell that Resident #40 was in the floor. Nurse #1 reported she worked the remainder of the shift and came back every couple of hours to check on him throughout the night and thought he was in pain because he would moan. Nurse #1 reported she had not administered any additional medication to Resident #40 because he was not assigned to her.

A physician's order dated 5/27/2024, at 10:54 pm, for Resident #40 revealed an order for an x-ray of the left hip and pelvis written by the MD. The order was entered by Nurse #3 after she called to report Resident #40's left leg was internally rotated and shorter than his right leg.

A radiology report dated 5/28/2024 at 9:37 am revealed Resident #40 had a dislocation of a left hip arthroplasty (a surgery to restore the hip joint) and an acute fracture of the proximal (close to the hip) left femur noted as new since 1/12/2024.

A progress note completed by PA #1, dated 5/28/2024, with no time noted, revealed Resident #40 was seen for evaluation after a fall on 5/27/2024. Resident #40 had complained of pain. The x-ray was reviewed and noted to have a fracture of the proximal left femur with lateral displacement. Resident #40 was recommended for hospital transfer for evaluation.

The physician's orders dated 5/28/2024 at 12:15 pm written by PA #1 revealed Resident #40 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 121	F 697		

to give an additional oxycodone-acetaminophen 5-325 mg tablet one time only for increased pain.

An interview was conducted on 6/4/2023 at 3:19 pm with PA #1. PA #1 reported she had been made aware the morning of 5/28/2024 of Resident #40's fall on 5/27/2024. PA #1 stated she was very familiar with Resident #40 and could tell on 5/28/2024 he was in a lot of pain and was grimacing. PA #1 reported she reviewed the x-ray of the left hip/pelvis and noticed an acute fracture. PA #1 reported she ordered an additional pain pill to be administered, and ultimately sent him to the hospital for further evaluation. PA #1 reported she had not been made aware Resident #40 had experienced increased pain throughout the night and would have expected nursing staff to report increased pain to the on-call provider. PA #1 reported Resident #40 was ordered oxycodone-acetaminophen 5-325 mg, 2 tablets, every 6 hours for pain on his arrival back to the facility.

Nurse #10 documented that she administered oxycodone-acetaminophen 5-325 mg tablet on 5/28/2024 at 12:19 pm, as scheduled, and documented a pain assessment of 8 out of 10 for Resident #40.

On 5/28/2024 at 1:15 pm, PA #1 ordered Resident #40 to be transferred to the hospital.

The Emergency Medical Services (EMS) report dated 5/28/2024 at 1:43 pm revealed Resident #40 had pointed to his left leg, and "made a grimacing face as if to say that it hurt" and there was obvious deformity noted in the left hip with inward rotation with no other obvious injuries

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 122	F 697		

were noted.

The Acute Care Hospital documentation dated 5/28/2024 through 5/29/2024 revealed Resident #40 presented to the Emergency department after he fell to the ground while transferring from his bed on 5/27/2024. Documentation revealed Resident #40 was complaining of pain and appeared to be less ambulatory. Resident #40 had an x-ray of his left hip and pelvis that demonstrated left hip arthroplasty with an associated fracture dislocation. Resident #40 was admitted to hospital further evaluation and pain management and medications were adjusted (he was administered hydrocodone-acetaminophen 5-325 mg every 6 hours) and his oxycodone was continued. Resident #40 was recommended nonsurgical interventions and was to follow up in two weeks with outpatient orthopedics. Resident #40 was discharged back to the facility on 5/29/2024.

The physician's orders dated 5/28/2024 at 6:00 pm revealed Resident #40 was ordered oxycodone-acetaminophen 5-325 mg, 2 tablets, every 6 hours for pain, and was discontinued on 5/31/2024.

The physician's orders dated 5/31/2024 at 12:00 pm revealed Resident #40 was ordered oxycodone-acetaminophen 5-325 mg every 4 hours for pain.

An observation and interview were conducted on 6/4/2024 at 1:16 pm. Resident #40 was lying in bed turned on his right size and pointed to his left upper outer thigh area, made a grimacing face and a squeezing motion with his hands. Resident #40 nodded "yes" that he had pain and mouthed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 123	F 697		

the pain medication only "helped a little."

An interview was conducted on 6/5/2024 at 8:41 am with the Director of Nursing (DON). The DON stated Nurse #3 had contacted her about Resident #40's fall the night of 5/27/2024. The DON stated Nurse #3 told her Resident #40's leg was internally rotated and shorter, and she advised Nurse #3 to contact the on-call provider and the family to see if Resident #40 should be transferred to the hospital for further evaluation. The DON stated she was not aware Resident #40 had experienced increased pain and the provider had not been notified. The DON stated staff were to report increased or uncontrolled pain to the provider.

An interview was conducted on 6/5/2024 at 3:09 pm with the MD. The MD reported she had been made aware on 5/28/2024 of Resident #40's fall on 5/27/2024 by PA #1. The MD stated PA #1 had Resident #40 sent to the hospital for evaluation because she was concerned how his leg looked. The MD reported PA #1 had adjusted Resident #40's pain medications after he returned to the facility and that she had seen him earlier on 6/5/2024 and he was smiling and had not appeared to be in pain. The MD was not aware of Resident #40's pain the night of his fall and reported staff should have reported increased or uncontrolled pain.

An interview was conducted on 6/7/2024 at 3:23 pm with the Administrator. The Administrator reported he knew Resident #40 fell on 5/27/2024 but had not been made aware Resident #40 had increased or uncontrolled pain that was not reported to the on-call provider. The Administrator agreed the on-call provider should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 124	F 697		

have been made aware of Resident #40's pain,

The Administrator was notified of Immediate Jeopardy on 6/5/2024 at 11:35 am.

The facility provided the following credible allegation of immediate jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to address Resident #40's pain to his left hip after sustaining a fall from his wheelchair which resulted in an acute fracture of the proximal femur.

Starting 6/6/24, the Director of Nursing and the licensed nurses will complete new pain assessments of the current residents to include review of progress notes, care plans and resident pain regiments to ensure resident pain is being managed and/or prevented. Interviewable residents will also be interviewed by the licensed nurse to ensure that their current pain regime is adequate.

All the current residents are at risk as a result of this deficient practice.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Starting 6/5/24, the Chief Nursing Officer reviewed the Maple Health Pain Management Prevention Plan with the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 125	F 697		

Starting 6/5/24, Director of Nursing and the Staff Development Coordinator will educate the licensed nurses, certified nursing assistants (CNA), and the certified medication aides (CMA) on identifying signs and symptoms of pain, and pain management and prevention to include follow up with the provider if pain management interventions are not effective. Pain will be assessed every shift, after a fall, with changes in condition and before and after pain medication administration and documented in the medication administration record or the progress notes.

Starting 6/5/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring licensed nurses, weekend nursing staff, CNAs, and CMAs receive the education to include identifying sign and symptoms of pain, and pain management and prevention to include follow up with the provider if pain management interventions are not effective. Staff including new hires and prn staff and agency staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff. The SDC will be responsible for ensuring the education is completed.

Effective 6/5/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/10/24

A validation of immediate jeopardy removal was conducted on 06/13/24. The initial pain assessments and interviews were reviewed with no issues noted. Licensed nurses were able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 697	Continued From page 126 verbalize that they had the education reguarding pain and that pain was assessed after a fall, with change in condition, before and after pain medication administration and would documented in the medical record. Non licensed staff were able to vervalize that if a resident complained of pain or indicated thier pain medication was not effective who to report that information too. The licensed nurses were able to verbalize the need to communicate to the medical provider and involve the responsibel party if the residents pain could not be managed in the facility and needed a higher level of care. The immediate jeopardy removal date of 06/10/24 was validated.	F 697		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 726	Continued From page 127 implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Director interviews the facility failed to ensure that Nurse Aides (NA) #3 and NA #4 knew how to respond to a medical emergency, and what role to assume during a medical emergency, and were certified in cardiopulmonary resuscitation (CPR) before participating in an emergency situation that resulted in performing CPR on Resident #70. On 06/03/24 Resident #70 went into sudden cardiac arrest and NA #3, NA #4, and NA #5 began CPR without the use of backboard which creates a hard surface for effective chest compressions that allows for adequate recoil (allow the chest to fully expand after compressions which pushes blood to vital organs). NA #3 and NA #4 were not certified in CPR for Healthcare Providers. During CPR Nurse #4 and the Staff Development Coordinator observed NA #3's compressions were not effective or deep enough to create recoil and had to instruct NA #3 that his compressions were not deep enough before switching out with the Staff Development Coordinator who could assist. EMS arrived and placed a backboard under Resident #70 and continued CPR. Resident #70 expired. In addition, Nurse #4 and the Staff Development Coordinator did not receive orientation on response to medical emergencies. The deficient	F 726	The facility failed to ensure that the staff were trained in Emergency Response, how to respond, when to respond, and their role during medical or clinical emergency situations in the facility. The facility also failed to complete staff competency checklists to include medical and clinical emergency responses, medical and clinical facility codes, and location of medical and clinical emergency equipment. Starting 6/7/24, the Staff Development Coordinator, Director of Nursing and Unit Manager will ensure that all staff to include nursing staff, administrative staff, dietary staff, laundry/ housekeeping staff, and maintenance staff complete competency checklists based on their job descriptions for medical and clinical emergencies, medical and clinical codes and location of medical and clinical emergency equipment to ensure staff is aware of how to respond in clinical and medical emergencies. Staff will not be allowed to participate in medical and clinical emergencies without completing the competency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 726	Continued From page 128 practice affected 5 of 5 staff reviewed for emergency procedure competencies. Immediate jeopardy began on 06/03/24 when NA #3 and NA #4 performed CPR on Resident #70 without being trained in CPR for Healthcare Providers. Immediate jeopardy was removed on 06/12/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete education and ensuring monitoring system put into place are effective. The findings included: This tag is cross referred to: F678: Based on observations, record review, staff, and Medical Director interviews the facility failed to ensure that Cardiopulmonary Resuscitation (CPR) was administered effectively when Resident #70 went into sudden cardiac arrest and CPR was initiated by Nurse Aide (NA) #3, NA #4, and NA #5 and continued for 7 minutes without a backboard. The backboard creates a hard surface for effective compressions that allow for adequate recoil (allowing the chest to fully expand after compression which pushes the blood to vital organs) and ensure perfusion for vital organs. During CPR Nurse #4 and the Staff Development Coordinator observed NA #3's compression were not effective or deep enough to create recoil and had to instruct NA #3 that his compressions were not deep enough before switching NA #3 out with another staff member that could assist. NA #3 and NA #4 were not	F 726	All the current residents are at risk as a result of this deficient practice. Starting 6/7/24, the Staff Development Coordinator will ensure all staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), licensed nurses, therapists, housekeeping/ laundry staff, dietary staff, social services, administrative staff, weekend staff, agency and prn staff complete competency checklists to include medical and clinical emergencies, medical and clinical facility codes and the location of medical and clinical emergency equipment. Staff, to include new hires and prn staff who have not completed the competency checklist by 7/16/24 will not be allowed to work in the facility. Starting 6/7/24, the Director of Nursing and Staff Development Coordinator (SDC) will educate the facility staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), licensed nurses, therapists, housekeeping/ laundry staff, dietary staff, social services staff, administrative staff, weekend staff, agency and prn staff on emergency responses to include how to respond, when to respond, and their role during medical and clinical emergency situations in the facility and where to find the medical and clinical emergency equipment located at the nursing stations. The night shift licensed nurses will complete the medical and clinical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 726	Continued From page 129 certified in CPR for Healthcare Providers. Emergency Medical Services (EMS) arrived and placed a backboard under Resident #70 and continued CPR. Resident #70 expired. A review of a document provided by the facility titled, "Orientation Overview" with no date noted, indicated that on day 1 and day 2 of orientation new staff would watch a video on emergency preparedness. The required paperwork was listed as CPR card (required for Nurses only, but good to have for other staff), facility codes and security access, and included a facility tour. A review of NA #3's training file revealed his date of hire was 04/24/24 and there was no Orientation and/or Skills Competencies on emergency situations, how to respond or what their role during an emergency was, and no CPR certification. There was no job description in the file. A review of NA #4's training file revealed his date of hire was 05/22/23 and there was no Orientation and/or Skills Competencies on emergency situations, how to respond or what their role during an emergency was, and no CPR certification. There was no job description in the file. A review of NA #5's training file revealed his date of hire was 05/01/23 and there was no Orientation and/or Skill Competencies on emergency situation, how to respond or what their role during an emergency was noted. There was an active CPR certification from the American Heart Association with an expiration of 07/2024. There was no job description in the file.	F 726	emergency equipment check list daily. The DON will check the medical and clinical emergency equipment and the completed medical and clinical check list weekly to ensure compliance. Staff, to include new hire and prn staff who have not completed the education by 7/16/24 will not be allowed to work without completing this education. The Director of Nursing/ Unit Manager will complete audits weekly x 4 weeks and monthly x 2 months of the medical clinical check lists completions, medical and clinical equipment check lists completions, and medical and clinical competencies completions on new hires, new agency, and prn staff. The Director of Nursing will present the findings of the weekly audits to the Quality Assurance Improvement Performance (QAPI) committee for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 726	Continued From page 130	F 726		

The NA job description dated December 2018 indicated that job requirements included a preference for current/active CPR certification.

A review of Nurse #4's training file revealed her date of hire was 03/06/24 and there was no Orientation and/or Skill competencies on medical emergency situations, how to respond or what her role during an emergency was. There was no CPR certification or job description noted in the file. Nurse #4 was able to produce a copy of her CPR certification from the American Heart Association with an expiration on 08/2024.

A review of the Staff Development Coordinator's training file revealed her date of hire was 05/22/24 and no Orientation and/or Skills Competencies on medical emergency situations, how to respond or what her role during an emergency was. There was no CPR certification or job description noted in the file. The Staff Development Coordinator was able to produce a copy of her CPR certification from the American Heart Association with an expiration on 07/2025.

The Nurse job description dated December 2011 indicated that job requirements included: current/active CPR certification. The essential duties and responsibilities included: confirm that all nursing personnel assigned to you comply with the written policies and procedures established by this facility and verify that all nursing service personnel are in compliance with their respective job descriptions.

NA #3 was interviewed via phone on 06/06/24 at 8:57 AM. NA #3 stated he had only been employed at the facility for a short time and his CPR certification had expired and was no longer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 726	Continued From page 131	F 726		

valid. NA #3 stated that when he came to work at the facility, he was given no training in medical emergencies, how to respond, where emergency equipment was located, and no training in CPR. He also stated he had not completed any competencies or skills check since coming to the facility.

The Staff Development Coordinator was interviewed on 06/06/24 at 10:27 AM. The Staff Development Coordinator stated that she had only been at the facility for less than a week and had not had the time to get the training program started but would be working on that in the future. She explained when she started, she was not given any information on location of emergency supplies or equipment, was told nothing about code situations, how to run one or what was supposed to be on the crash cart or where the crash carts were located. She stated she had to ask the DON where the crash cart was located during the emergency situation on 06/03/24. She added that her CPR certification was active and was also trained in advance life support as well.

The DON was interviewed on 06/06/24 at 11:14 AM. She explained she had been at the facility since January 2023, and she had not had consistent staff and no one to oversee the training program. The Staff Development Coordinator was only recently hired and had not had the time to develop and implement all the things that needed to be done at the facility. She stated that at the bare minimum staff should be given a tour of the facility and shown where the crash carts and emergency equipment were located. The DON was asked for the training records for NA #3, NA #4, Nurse #4, and the Staff Development Coordinator and she stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 726	Continued From page 132	F 726		

there were none because she had not had a staff member in that role consistently since she started in January 2023. She stated that she had plans with the Staff Development Coordinator from a sister facility to come over and train their current Staff Development Coordinator and set up the orientation manual like she wanted, to ensure that all staff received the required training. She further stated that a part of that training was going to include skills and competencies for each staff member. The DON stated that currently new staff were brought into the facility given a quick tour of the facility and then sent out with a staff member to be trained.

The Administrator was interviewed on 06/06/24 at 4:10 PM. He explained the previous Staff Development Coordinator had started the training program but when they began requesting the training she was unable to produce it, so they had to part ways with the employee which created a long-term vacancy in that position.

The Administrator was notified of the immediate jeopardy on 06/05/24 at 5:13 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to ensure that the staff were trained in Emergency Response, how to respond, when to respond, and their role during medical or clinical emergency situations in the facility. The facility also failed to complete staff competency checklists to include medical and clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 726	Continued From page 133	F 726		

emergency responses, medical and clinical facility codes, and location of medical and clinical emergency equipment.

Starting 6/7/24, the Staff Development Coordinator, Director of Nursing and Unit Manager will ensure that all staff to include nursing staff, administrative staff, dietary staff, laundry/ housekeeping staff, and maintenance staff complete competency checklists based on their job descriptions for medical and clinical emergencies, medical and clinical codes and location of medical and clinical emergency equipment to ensure staff is aware of how to respond in clinical and medical emergencies. Staff will not be allowed to participate in medical and clinical emergencies without completing the competency.

All the current residents are at risk as a result of this deficient practice.

o Specify the action the entity will take to alter the process or system complete.to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Starting 6/7/24, the Staff Development Coordinator will ensure all staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), licensed nurses, therapists, housekeeping/ laundry staff, dietary staff, social services, administrative staff, weekend staff, agency and prn staff complete competency checklists to include medical and clinical emergencies, medical and clinical facility codes and the location of medical and clinical emergency equipment.

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 726	Continued From page 134	F 726		

Starting 6/7/24, the Director of Nursing and Staff Development Coordinator (SDC) will educate the facility staff to include the certified nursing assistants (CNA), certified medication assistants (CMA), licensed nurses, therapists, housekeeping/ laundry staff, dietary staff, social services staff, administrative staff, weekend staff, agency and prn staff on emergency responses to include how to respond, when to respond, and their role during medical and clinical emergency situations in the facility and where to find the medical and clinical emergency equipment located at the nursing stations. The night shift licensed nurses will complete the medical and clinical emergency equipment check list daily. The DON will check the medical and clinical emergency equipment and the completed medical and clinical check list weekly to ensure compliance.

Starting 6/7/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring licensed nurses, weekend staff, CNAs, therapists, housekeeping/laundry staff, dietary staff, social services staff, administrative staff and CMAs including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff. The SDC will be responsible for ensuring the education is completed.

Effective 6/7/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 6/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 726	Continued From page 135 A validation of immediate jeopardy removal was conducted on 06/13/24. Staff across all departments were able to verbalize that they had received education on responding to emergenices, thier individual role in emergencies, how to respond, location of emergency equipment, and who was able to render care during an emergency. The non lisenced staff were able to report that they could contact EMS services, direct them to the appropriate place, and gather supplies as instructed by the licensed Nurse. The licensed nurse were able to report their role in an emergency, how to direct the non licensed staff, initating and rendering emergency care. Review of the emergency checklist revealed that the staff had been ensuring the emergency equipment was stocked and ready for use each night since 06/03/24. The immediate jeopardy removal date of 06/12/24 was validated.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 758	Continued From page 136 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, Resident, staff, Physician Assistant, Medical Director and Consultant Pharmacist interviews the facility failed to limit the use of a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) ordered on	F 758	Resident #32 was seen by the Physician Assistant on 6/7/24 for medication review with compound lorazepam gel stop/ reassessment date for 7/7/24. Residents as needed psychotropic medications are at risk for this deficit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 758	Continued From page 137 an as needed (PRN) basis to 14 days and/or indicate the duration for the PRN order to be extended beyond 14 days. The facility also failed to identify the lack of monitoring for side effects of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #32). The findings included: Resident #32 was admitted to the facility on 11/15/23 with diagnoses that included antianxiety disorder, bipolar disorder, depression and schizoaffective disorder. A review of Resident #32's Minimum Data Set (MDS) assessment dated 05/11/24 revealed she was cognitively intact. The MDS also indicated rejection of care occurred 1-3 days, physical behaviors directed toward others occurred 1-3 days, verbal behaviors directed toward others occurred 4-6 days and other behaviors not directed toward others occurred 1-3 days during the look back period. The MDS included the use of antianxiety, antidepressant and antipsychotic medications. a. A review of Resident #32's physician order dated 05/13/24 revealed an order for compound lorazepam gel (a topical gel made from a combination of lorazepam an antianxiety medication used to treat anxiety, a histamine medication that causes drowsiness and an antipsychotic used to treat psychosis) apply to wrist topically every 4 hours as needed (PRN) for agitation. There was no stop date or indication for the PRN order to be extended beyond 14 days. A review of Resident #32's May and June 2024	F 758	practice. Director of Nursing/ Unit Manager will complete audit by 7/16/24 of residents that receive as needed (PRN) psychotropic medications to ensure 14 days stop dates or indications for PRN order to be extended beyond the 14 days are included in the orders. The Chief Nursing Officer will educate the Director of Nursing on 7/5/24 related to ensuring ongoing monitoring and/or review during morning clinical meeting of residents that receive PRN psychotropic medications without 14 days stop dates or indications for extended usage for follow up with the provider. The Director of Nursing/ Unit Manager will complete education of the licensed nurses to include agency, weekend, and prn nurses on unnecessary psychotropic medication usage to include ensuing PRN orders for psychotropic medications should be limited to 14 days and if extended beyond 14 days residents should be evaluated by the provider for appropriateness of continued use. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure all current licensed nurses and medication aides who have not received this education by July 16, 2024, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired licensed nurses and medication aides, to include agency staff, will receive education during facility orientation prior to working. The Director of Nursing/Unit Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 758	Continued From page 138 Medication Administration Record revealed the compound lorazepam gel was administered 13 times. During an interview with the Consultant Pharmacist on 06/07/24 at 9:25 AM the Pharmacist explained that the psychotropic medications ordered on an as needed (PRN) basis must have a stop date and or the indication of the usage past a 14-day duration. The Pharmacist acknowledged Resident #32's recent 05/13/24 physician order for the compound lorazepam gel which did not have a stop date or an indication of usage past a 14 day duration and indicated the order was not complete with the stop date or an indication of usage past a 14-day duration. An interview was conducted with the Physician Assistant (PA) on 06/07/24 at 2:49 PM. The PA acknowledged that Resident #32's order for the compound lorazepam gel did not contain a stop date or an indication of usage past the 14-day duration and stated the pharmacy revised the order on 05/13/24 and did not put a 30 day stop date on the order which was what she normally ordered for Resident #32. On 06/07/24 at 9:54 AM during an interview with the Director of Nursing (DON) she explained that there had to be a stop date for PRN psychotropic medications, or the physician should indicate a specific stop date if it extends past 14 days. b. A review of Resident #32's physician orders from admission on 11/15/23 through 06/07/24 specifically for psychotropic medications revealed various orders for psychotropic medications were ordered and administered to Resident #32 since	F 758	will complete audits of PRN psychotropic medications weekly x 4 weeks and monthly x 2 months. The Director of Nursing/Unit Manager will report the findings of the QA monitoring monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 758	Continued From page 139	F 758		

her admission included:
*11/15/23 Clonazepam (antianxiety) 0.5 milligram (mg) by mouth one time a day in the morning for anxiety.
*11/15/23 Clonazepam 1 mg by mouth in the evening for anxiety.
*11/15/23 Quetiapine Fumarate (antipsychotic) 300 mg by mouth at bedtime for bipolar disorder.
*11/15/23 Sertraline (antidepressant) 100 mg by mouth one time a day for depression.
*01/22/24 Clonazepam 1 mg by mouth three times a day for anxiety.
*01/30/24 Haloperidol (antipsychotic) 0.5 mg by mouth in the morning for delusional disorder monitor for signs and symptoms and inform provider of present.
*05/02/24 Sertraline 50 mg by mouth one time a day for depression.
*05/10/24 Quetiapine Fumarate 200 mg by mouth twice a day for schizoaffective disorder.
*05/13/24 revealed an order for compound lorazepam gel (a topical gel made from a combination of lorazepam an antianxiety medication used to treat anxiety, a histamine medication that causes drowsiness and an antipsychotic used to treat psychosis) apply to wrist topically every 4 hours as needed (PRN) for agitation.

A review of Resident #32's Medication Administration Records (MAR) from 11/2023 through 06/2024 indicated the Resident was ordered and administered psychotropic medications during the timeframe and there were no monitoring tools present on the MARs to indicate the psychotropic medications were being monitored for side effects of the medications.

A review of Resident #32's care plan revised on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 758	Continued From page 140	F 758		

02/19/24 revealed the Resident used psychotropic medications related to behavioral management and bipolar disorder. The goal is that the Resident would remain free of drug related complications including movement disorder, discomfort, hypotension, gait disturbances, constipation/impaction, or cognitive/behavioral impairment. The interventions included monitoring/document/report any adverse reactions of psychotropic medications such as unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting and behavioral symptoms not usual for the resident.

On 06/03/24 at 11:20 AM an interview was attempted with Resident #32 who stated she did not feel like talking at that time.

On 06/04/24 at 9:43 AM Resident #32 lying in bed sleeping with her breakfast tray on her over bed table in front of her. Approximately ¾ of meal consumed. The Resident was not easily awakened when her name was called.

On 06/05/24 at 2:56 PM an observation was made of Resident #32 lying in bed awake and when asked if she wanted to talk the Resident only stated she just wanted to get washed up and get out of the bed. The request was reported to Nurse Aide #10.

An interview was conducted with Nurse #15 on 06/05/24 at 2:56 PM who explained that Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 141	F 758		

#32 was alert but not always oriented. She required assistance with her activities of daily living but could feed herself. The Nurse reported the Resident had verbal and physical behaviors toward the staff and did what she wanted to do like when she wanted to stay in the bed.

On 06/05/24 at 2:46 PM during an interview with the Medical Director (MD) she explained that Resident #32 had her pleasant days and not so pleasant days, and it was challenging to get her medications even in her blood system. She indicated the Resident could be both verbally and physically aggressive with the residents and staff. When asked about how she managed the Resident's psychotropic medications the MD stated the Physician Assistant (PA) managed the medications and if she had concerns PA would address them with her.

An interview was conducted with Social Worker (SW) #1 on 06/06/24 at 10:23 AM who explained that Resident #32 was alert but confused and thinks she was in the soap opera. She also believes that she was here to work and has a job hiring and firing the staff and that was why she stayed in the Director of Nursing's (DON) office a lot. She can be rowdy and refuse her medications and personal care depending on her days and moods. The SW continued to explain that Resident #32 had physical behaviors like hitting and punching the staff and she had psychiatry referrals as well as talk therapy. She indicated that the facility tried to keep her separated from the residents that she had physical behaviors toward and that was another reason why she stayed in the DON's office. When asked where the staff documented Resident #32's behaviors she indicated the progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 142 On 06/07/24 at 9:25 AM an interview was conducted with the Consultant Pharmacist. The Pharmacist explained that she did not believe the facility used monitoring tools for documentation of side effects of the psychotropic medications, so she looked through the psychiatry and PA notes during the monthly reviews. During an interview with the Director of Nursing (DON) on 06/07/24 at 9:54 AM the DON explained that the facility monitored for the side effects of the psychotropic medications by putting the monitoring tools on the MAR under the specific medication. When the DON reviewed Resident #32's MARs since her admission in November 2023 she acknowledged the Resident did not have any monitoring tools set up for the psychotropic medications. The DON stated the Pharmacist must have missed that during her monthly reviews of her chart. An interview conducted with the Physician Assistant (PA) on 06/07/24 at 2:49 PM. The PA explained that she has had to change and adjust Resident #32's psychotropic medications multiple times due to her behaviors and diagnoses. When asked how she monitored the side effects of the psychotropic medications she indicated she monitored for the side effects of the psychotropic medications herself because was in the facility all the time.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 759	Continued From page 143 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by having 3 medication errors out of 27 opportunities, resulting in a medication error rate of 11.11%. This affected 2 of 7 residents reviewed for medication pass (Resident #99 and Resident #51). The findings included: 1. Resident #99 was admitted to the facility on 05/29/24 with diagnoses that included exacerbation of chronic obstructive pulmonary disease (COPD) and allergies. A review of Resident #99's physician orders revealed an order with the start date of 06/02/24 for Prednisone (a steroid) 10 milligrams (mg) give 3 tablets by mouth once a day for 3 days for pneumonia and Tiotropium bromide (a bronchodilator) 2.5 MCG/ACT aerosol inhalation solution inhale 2 puffs orally once a day for exacerbation of COPD. On 06/04/24 at 9:44 AM Medication Aide (MA) #2 was observed as she prepared to medicate Resident #99. The MA administered 7 medications to the Resident which included one Prednisone 10 mg tablet and did not include the Tiotropium bromide inhaler. An interview was conducted with MA #2 on 06/04/24 at 2:35 PM. The MA explained that she thought she gave Resident #99 three Prednisone	F 759	Resident #51 was seen on 6/7/24 by the Physician Assistant with no concerns identified. Resident #99 was seen on 6/4/24 by the Physician Assistant with no concerns identified. On 6/26/24, Unit Manager conducted medication pass observation with MA#1. Medication errors rate was 0 %. On 6/27/24, Chief Nursing Officer conducted medication pass observation with MA #2. Medication errors rate was 0%. On 7/16/2024, the pharmacy nursing consultant will be in the facility to complete medication pass observations with licensed nurse and certified medication aides. On 6/26/24, the Unit Manger begin educating licensed nurses and certified medication aides, agency, prn, and new hire licensed nurses on Medication Administration to include medication pass observation competencies, 6 rights to medication administrator, handwashing, checking vital signs as indicated, not leaving medications at bedside, and ensuring medication carts are locked when unattended. New hires will complete medication pass observation competencies as part of orientation. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure all current licensed nurses and medication aides who have not received	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 759	Continued From page 144 tablets and the reason she did not give her the inhaler was because she thought the Resident had the inhaler at her bedside and could medicate herself. There was no Tiotropium bromide inhaler in the Resident's room. 2. Resident #51 was admitted to the facility on 07/10/23 with diagnoses that included gastrointestinal reflux disease (GERD). A review of Resident #51's physician orders revealed an order for famotidine 20 mg by mouth two times a day for GERD with a start date of 01/30/24. On 06/04/24 at 10:20 AM Medication Aide #1 was observed as she prepared to medicate Resident #51. The MA administered 14 medications to the Resident which included one famotidine 10 mg tablet. An interview with MA #1 on 06/04/24 at 2:30 PM. The MA was asked to show the bottle of famotidine that she used to medicate Resident #51 earlier that morning and the MA obtained a bottle of famotidine from the medication cart that indicated famotidine 10 mg tablets. The MA read the order and the contents of the label and confirmed she did not give the Resident 2 tablets of the famotidine. She stated she needed to pay closer attention to the label. During an interview with the Director of Nursing (DON) on 06/07/24 at 9:34 AM the DON was informed of the 11.11% medication error rate made by the two Medication Aides. She indicated both would be further educated on medication pass procedures.	F 759	this education by July 16, 2024, will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired licensed nurses and medication aides, to include agency staff, will receive education during facility orientation prior to working. The Director of Nursing/Unit Managers will complete medication pass observations twice a week x 4 weeks, weekly x 4 weeks, and then biweekly x 2 weeks to include the weekend licensed nurses and medication aides. The Director of Nursing/Unit Manager will report the findings of the QA monitoring monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 761	Continued From page 145	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to remove open and expired medications from 2 of 2 medication rooms (front and back medication rooms), failed to remove open and undated medication from 1 of 4 medication carts (300 hall medication cart), failed to secure medications in 1 of 4 medication carts (500/700 hall medication cart) and failed to secure a controlled substance medication under	F 761	On 6/3/2024, Nurse #13 placed the insulin pens in the locked medication cart. On 6/5/2024, Nurse #10 discarded the open foil packs. On 6/7/24, Nurse #14 placed the insulin pens in the locked medication cart. On 6/5/2024, Nurse #5 discarded the expired Tuberculin solution and locked the refrigerator emergency Ativan medication	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 761	Continued From page 146 double lock (back medication room) in 1 of 2 medication rooms (back medication room) for review of medication storage. The findings included: 1a. On 06/03/24 from 11:51 AM to 11:52 AM an observation was made of the unlocked medication cart for 500/700 halls parked in the 700 hallway with 8 residents' insulin pens left unattended on top of the medication cart. Multiple staff and a visitor were observed to walk past the unlocked medication cart. An interview was conducted with Nurse #13 on 06/03/24 at 11:52 AM as she exited a resident's room. Nurse #13 acknowledged the cart was left unlocked and the insulin pens were left unsecured on top of the cart while she went into the resident's room to administer insulin. The Nurse explained that she should not have left the insulin pens on top of the cart because the pens should be secured and locked. 1b. On 06/05/24 at 3:25 PM an observation was made of the 300 hall medication cart accompanied by Nurse #10. The observation yielded one open and undated foil pouch of albuterol sulfate and ipratropium bromide (duoneb vials, breathing medication) that were available and ready for use. An interview with Nurse #10 on 06/05/24 at 3:25 PM revealed she acknowledged the foil pouch was open and undated and stated she did not know how long the duobeb vials could remain in the open pouch undated. 1c. On 06/07/24 at 4:30 PM an observation was	F 761	box. On 6/10/24, the Unit Manager began auditing all facility medication carts for undated medications, insulin pens unattended on top of medication carts, expired medications, and foil packs not dated. All labeling and storage were correct. On 6/10/24, the Unit Manager inspected the front and back medication rooms and refrigerators for expired medications. Expired medications were discarded and the emergency medication box continued to be locked. Starting 6/15/24, Unit Manager began educating all current licensed nurses and medication aides on labeling and storing of drugs and biologicals. The Director of Nursing/Unit Manager will ensure all current licensed nurses and medication aides who have not received this education by 7/16/24 will not be allowed to work until education is completed. The Director of Nursing/Unit Manager will ensure newly hired licensed nurses and medication aides, to include agency staff, will receive education during facility orientation in-person or via telephone prior to working. The Director of Nursing/Unit Manager will complete inspections of the medication carts and medication rooms to include insulin leave unsecured on top of the medication cart, expired medications, undated opened foil packs, expired medication in the medication refrigerators and unlocked emergency medication boxes in the refrigerators twice a week x 4 weeks, weekly x 4 weeks, and then biweekly x 2 weeks. The Director of	

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	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 761	Continued From page 147 made of the 500/700 halls medication cart which was left unattended at the nursing desk. The medication cart had 4 insulin pens on top of the cart. Multiple staff were observed to walk by the medication cart and a resident was seated in his wheelchair near the desk. An interview was conducted with Nurse #14 on 06/07/24 at 4:36 PM who confirmed she was responsible for leaving the insulin pens unattended on top of the medication cart. She stated she had to step away from the cart for a few minutes and that she should have secured the pens in the locked cart before she walked away. During an interview with the Director of Nursing (DON) on 06/07/24 at 9:38 AM and 4:57 PM and a follow-up interview on 06/13/24 at 5:25 PM the DON explained that the insulin pens should never be left unattended on the medication carts, and Nurse #14 should have put them in the cart before she walked away from the cart. 2a. A review of the front medication room was made on 06/04/24 at 4:01 PM along with Nurse # 12 and revealed the following expired medications that were on the shelf or in the refrigerator and available for use: -2 unopened bottles of bisacodyl (laxative) 5 milligrams (mg) that expired on 02/24. -1 unopened bottle of melatonin 1 mg that expired on 04/24. -1 opened and partially used three fluid ounce bottle of omeprazole powder 2mg that stated do not use after 05/06/24. -1 vial of tuberculin protein derivative 1 milliliters (ml) vial that was opened on 04/30/24 and labeled with a discard date of 05/30/24.	F 761	Nursing/Unit Manager will report the findings of the QA monitoring monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 761	Continued From page 148	F 761		

-1 bottled of opened cephalexin (antibiotic) 250 mg/5 milliliters (ml) 100 ml bottle labeled to discard after 03/12/24.

Nurse #12 was interviewed on 06/04/24 at 4:08 PM. Nurse #12 stated it was her second day at the facility via an agency. She had no idea what to do with the expired items, but she would take them and find out. She was also unaware of who was responsible for checking the medication room and refrigerator for expired medication.

2b. An observation was made of the refrigerator in the back medication room on 06/05/24 at 2:57 PM accompanied by Nurse #5. The observation yielded:
-1 open vial of Tuberculin solution (PPD) with an open date of 05/01/24.
-The controlled substance box affixed to the refrigerator was not locked and contained 32 lorazepam gel packs.
-1 lorazepam vial in the emergency medication box that was not affixed to the refrigerator and was not locked.

An interview was conducted with Nurse #5 on 06/05/24 at 2:58 PM who confirmed that she counted the controlled substance medication in the box affixed to the refrigerator that morning during change of shifts and forgot to lock the box afterwards. Nurse #5 stated she did not realize the facility kept the lorazepam vial in the unlocked box but that it probably needed to be in the locked box as well. Nurse #5 acknowledged the date on the PPD solution and stated it should only be kept for 28-30 days and stated she would throw it away. She stated that third shift was responsible for checking the refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 761	Continued From page 149 During an interview with the Director of Nursing (DON) on 06/07/24 at 9:38 AM and 4:57 PM and a follow-up interview on 06/13/24 at 5:25 PM the DON explained that she had posted pharmacy medication storage sheets on the medication carts for the nurses to use as a guide to assist them in knowing how and where the medications should be stored. The DON stated the medication rooms and refrigerators were checked weekly by the day shift nurses and should have found the out-of-date medications and disposed of them. She indicated the controlled substances should always be behind double lock and key.	F 761		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Director (MD) interviews the facility failed to ensure the MD was aware of resident care policies related to Cardiopulmonary Resuscitation (CPR) and Emergency Response. This deficient practice had the potential to affect all current residents in the facility. The findings included: A review of the Medial Director service agreement signed by the facility's Medical Director (MD) on	F 841	The Administrator educated the Medical Director on 6/19/2024 on Cardiopulmonary Resuscitation (CPR) and Emergency Response policies. The current residents are at risk for this deficient practice. The Director of Operations educated the Administrator and the Director of Nursing on 6/27/24 on ensuring the Medical Director remains updated on resident care policies.	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 841	Continued From page 150 12/29/17 included the following under duties and obligations of Medical Director: Medical Director shall be responsible for implementation of resident care policies, coordination of medical care in the facility and shall perform such other duties and responsibilities customary for a medical director in a facility of comparable size to the facility. The Medical Director (MD) was interviewed on 06/05/24 at 2:55 PM. The MD stated she was not familiar with the protocol for CPR or Emergency Response in the building, but she had always told the facility to call EMS before calling her. The Administrator was interviewed on 06/13/24 at 4:46 PM. The Administrator stated the MD was a contracted employee and evaluated residents as outlined by the regulation and as needed. The MD visited the facility each week and played a part in every major medical decision made, had input on policies, attended the Quality Assurance meeting and made recommendations as needed. The Administrator stated the MD had access to all the facility policies and then staff would supplement that with any education needed. He stated, "it is very important for her to be informed of the policies of this building" and anything to do with the residents in our building.	F 841	The Administrator will ensure new Medical Directors are educated and receive updates on resident care policies to include CPR and Emergency Reponse policies. The Administrator will ensure that resident care policies changes are being reviewed/ revised in the monthly Quality Assurance Performance Improvement (QAPI) team meeting to ensure continual compliance.	
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	F 842		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 151	F 842		

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.

§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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 152 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 record review, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to ensure accurate medical records when a resident's labs were incorrectly documented as collected for 1 of 1 resident (Resident #196) reviewed for medical record accuracy. The findings included: Review of a physician order dated 12/25/23 read; Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) related to increased confusion per family members observation. A review of Resident #196's December 2023 Medication Administration Record indicated Nurse #6 had collected a CBC and BMP on	F 842	Resident #196 was discharged from the facility on 12/26/23. Nurse #6 no longer works in the facility. Current residents are at risk for this deficient practice. The Director of Nursing/Unit Manager will complete a review of the medical administration record (MAR) to include laboratory documentation of the current residents for the last 30 days by 7/16/24 to ensure the documentation is accurate. The Director of Nursing/Unit Manager will follow up with the provider any identified inaccuracies. The Director of Nursing/Unit Manager will educate the licensed nurses by 7/16/24 to include weekend, agency and prn staff on ensuring MAR documentation is accurate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 153 12/25/2023 at 1:24 am. An interview was conducted on 6/4/2024 at 8:36 pm with Nurse #6. Nurse #6 reported she worked on 12/24/2023 during the night shift (7:00 pm to 7:00 am) and was assigned Resident #196. Nurse #6 stated after she had started her shift, Resident #196's Representative (RR) reported Resident #196 had acted more confused. Nurse #6 reported she had not obtained laboratory testing that night because she never drew blood at night and was not able to draw blood. Nurse #6 was not able to recall documenting that she had collected Resident #196's labs, and was not sure why it was documented that she had on the MAR. An interview was conducted on 6/7/2024 at 8:35 am with the DON. The DON verified Nurse #6 had documented she had collected Resident #196's labs on 12/25/2023 at 1:24 am. The DON stated since she had documented it, she would have expected labs to have been obtained at that time. The DON was not aware Resident #196 never had his labs collected.	F 842	to include laboratory documentation. New hire licensed nurses will receive this education in orientation. Nurses will not be allowed to work until the education is completed. The Director of Nursing will complete audits weekly x 4 weeks and monthly x 2 months of residents' MARs to include laboratory documentation. The Director of Nursing will report the findings to the monthly Quality Assurance Improvement Plan (QAPI) committee for review and/or revision to ensure continual compliance.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Pest Control Technician interviews the facility failed to maintain an effective pest control program as evidenced by the presence of flies on 1 of 7 hallways that affected resident rooms 308	F 925	Resident rooms 308 and 311 were treated for flies by the Maintenance Director on 6/4/24. On 6/6/24, Pest control services treated the facility for flies.	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 925	Continued From page 154 and 311. The findings included: Review of the pest control log receipt from April 2024 read: inspected and treated selected areas. Performed exterior rodent service, checked accessible bait stations and replaced bait as needed. Performed interior rodent service, checked and reset all traps. No rodent or insect activity was noted during inspection and/or service. Fly program serviced. Glue boards were 25% full, glue boards replaced. Review of the pest control log receipt from May 2024 read: inspected and treated selected areas. Performed exterior rodent service, checked accessible bait stations and replaced bait as needed. Performed interior rodent service, checked and reset all traps. No rodent or insect activity was noted during inspection and/or service. Fly program serviced. No cockroach activity was noted during inspection and/or service. Review of work order dated 06/04/24 read: staff reported flying insects in rooms 308, 311, and 112. Sprayed in all three rooms around air conditioning and various places on the wall to stop the flying insects. The work order was filled out by the Director of Nursing (DON) and completed by the Maintenance Director. Review of the pest control log receipt from June 06, 2024, read; "site reached out yesterday but I was unable to be here that day." Location/Guest rooms: findings: large flies noted during service. Treated rooms for flies in facility." Rooms treated: 311, 308, 113, 103, and 411. "Treated rooms for	F 925	On 6/6/24, three fly boards were installed by the maintenance staff in the courtyard area, smoking area, and on the service hall. The current residents are at risk for this deficient practice. By 7/5/24, the nursing staff will check resident rooms for open food items. The facility will supply resealable containers as needed to ensure proper food storage. The Administrator will send out letters to residents and resident families by 7/16/24 related to proper food storage and ensuring resident foods are in resealable containers. The Director of Operations educated the Administrator on 6/27/24 related to the pest control program and ensuring that rooms are being treated for flies as needed and preventative measures remain in place. The facility staff to include licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), housekeeping/laundry staff, therapy staff, dietary staff, administrative staff, social services, maintenance staff, prn staff, agency staff, and weekend staff will be educated by 7/16/24 by the Director of Nursing /Unit Manager on ensuring that when flies are identified this is placed in the maintenance log binder for follow and food items in resident rooms are being stored in resealable containers. Education will be ongoing to include new hires. Staff will not be allowed to work without completing this education. The Administrator will educate the maintenance staff by 7/16/24 on ensuring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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F 925	Continued From page 155 flies, while treating I noticed that most of the rooms had food material in them some under bed. I highly suggest cleaning the rooms out entirely for a reset of the room. Not only will food attract ants but flies too as they will eat it and once it degrades will lay eggs in it. Some rooms had flies in empty bed which leads me to believe the bodily fluids and other material could be embedded in the bed which would attract flies to them as well. I was given a list of rooms to treat and did so. Will bring fly panel for outside installation." a. An observation of a resident in Room 311 was made on 06/03/24 at 11:05 AM. There were 2 flies that were flying around and landed on the resident's bed which she was resting in at the time. An observation of a resident in Room 311 was made on 06/03/24 at 2:20 PM. There were flies noted in the resident's room and would land on the bed, the resident's hand, and on the wheelchair armrest that the resident was sitting in. An observation of a resident in Room 311 was made on 06/04/24 at 9:00 AM. The resident was in her wheelchair sitting beside her bed. There were large flies noted to be flying in her room and landed frequently on her bed. There was a fly swatter hanging by the door of her room. An observation of a resident in Room 311 was made on 06/04/24 at 1:16 PM. The resident was up in her wheelchair sitting next to her bed. There was a large fly on her bed. The fly swatter remained hanging from the wall next to her door.	F 925	that the maintenance log binder is being checked and follow-up is being completed when flies are identified in resident rooms and/or the facility. Education will be ongoing to include new hires. Staff will not be allowed to work without completing this education. The Maintenance Director will check at least 10 resident rooms to include halls ways, dining room, activity room and conference room weekly x 4 weeks and monthly x 2 months and report the findings to the Quality Assurance Improvement Plan (QAPI) committee for review and/or revision to ensure continual compliance. The Director of Nursing/Unit Manager will check at least 10 resident rooms weekly x 4 weeks and monthly x 2 months for open food not secured in a resealable container. The Director of Nursing will report the findings to the QAPI committee for review and/or revision to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 925	Continued From page 156	F 925		

An observation of a resident in Room 311 was made on 06/04/24 at 3:40 PM. The resident was resting in her bed. There was a fly noted on her abdomen and on the arm of her wheelchair next to her bed. The fly swatter remained hanging from the wall next to her door.

An observation of a resident in Room 311 was made on 06/05/24 at 12:38 PM. The resident was not in her room at the time, but her roommate was being assisted with the lunch meal in the room. There was a fly noted the residents bed and wall. The fly swatter remained hanging from the wall next to her door.

b. An observation of Room 308 was made on 06/03/24 at 3:50 PM. Room 308 was observed to have open food containers sitting on nightstands, bedside tables, and on the floor, they varied from open ceral boxes to open beverage containers. There was a urinal that had a dark yellow fluid noted sitting without a lid on one of the nightstands in the room. The floor was noted to be sticky and was so sticky it pulled the shoe of the surveyor off while walking from one side of the room to the other. There were large flies noted to be landing on the resident's pillow and bed.

An observation Room 308 was made on 06/04/24 at 10:12 AM. Room 308 was observed to have open food containers sitting on nightstands, bedside tables, and on the floor, they varied from open ceral boxes to open beverage containers. There were large flies noted to be landing on the resident's pillow and bed.

An observation of Room 308 was made on 06/04/24 at 1:16 PM. The resident was not in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 925	Continued From page 157	F 925		

room at the time, but large flies were noted on his bed and pillow.

An observation of Room 308 was made on 06/04/24 at 3:43 PM. Room 308 was observed to have open food containers sitting on nightstands, bedside tables, and on the floor, they varied from open ceral boxes to open beverage containers. There were large flies noted to be landing on the resident's pillow and bed and in the hallway directly in front of room 308.

An observation of Room 308 was made on 06/05/04 at 12:38 PM. There was a fly noted on the resident's bed.

An observation of Room 308 was made on 06/05/04 at 4:20 PM. There was a fly noted on the resident's bed.

An interview was conducted with Nurse Aide (NA) #12 on 06/04/24 at 9:00 AM. NA #12 stated that she worked at the facility 3 days a week and had not noticed any flies. NA #12 was asked to observe Room 308 and Room 311 and the flies that were present in both areas and NA #12 walked away from the surveyor and pointed to the smoking exit door that was just 2 doors down.

An interview was conducted with the Housekeeper on 06/04/24 at 3:35 PM. The housekeeper stated he was the permanent housekeeper on the 300 unit and cleaned those rooms each day he worked. The housekeeper stated that he had noticed the flies in room 308 and 311 often and believed that they came from the open food in room 308 and also the body odor of the residents in addition to the smoking exit door that was just down the hall. He further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 925	Continued From page 158	F 925		

explained that he had nothing on his cart to treat flies with but stated that the resident in 308 had just asked him for fly swatter.

During a resident council meeting held on 06/05/24 at 10:00 AM, the council reported seeing flies for the last week or so especially around the exit door and they had mentioned it to the Administrator.

The Maintenance Director was interviewed on 06/05/24 at 4:24 PM who stated that resident and staff started complaining of flies, so 2 to 3 months ago he put an air curtain up at the smoking exit door because the flies were not supposed to be able to fly through it. The Maintenance Director explained the smoking exit door had an interior door to the facility that could be closed but the residents were not able to open it, so it stayed propped open. Then the exit door to the smoking area had a handicapped door which was equipped with a delay to allow wheelchairs to pass through the door before it closed. He added that if staff said something about flies in a particular resident room, he would spray that room with a chemical that the pest control company gave him that could be used in resident rooms safely. He confirmed that he had treated rooms on 100 and 300, that included room 308 and also called for an extra visit from the Pest Control company on 06/05/24. The Maintenance Director stated that they had fly lights but only in the service hall but not on any resident hall or commons areas in the facility.

An interview with the Pest Control Technician was conducted on 06/06/24 at 10:04 AM. He explained the facility had reached out to him yesterday to come and treat for flies but he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 925	Continued From page 159	F 925		

unable to get to the facility yesterday (06/05/24). The technician stated that there was evidence of flies in several rooms including 308 and 311. He believed that the flies in room 308 (Resident #10's room) was directly related to the open food containers and urinal that had yellow fluid in it which both attracted flies. The technician stated that both resident rooms were empty at the time, and he was able to treat the entire room but "they have to eliminate the source" referring to the facility staff. He continued to say that the other rooms he treated had residents in them and he was only able to treat low level areas of their rooms. The Technician stated that during his observations he noted several flies on beds and pillows which indicated that the mattress and pillow may have excrement embedded in them and that was attracting flies and recommended replacing both if the facility was able to do so. He added that he had treated the smoking exit door and despite the air curtain flies could get still through it. The Technician recommend adding some external fly bait stations that the Maintenance Director approved.

The Director of Nursing (DON) was interviewed on 06/06/24 at 10:54 AM. The DON's office was located diagonally across from the smoking exit door. There were flies noted in her office flying and she stated she had noticed them and put a work order in for Maintenance to treat them.

The Administrator was interviewed on 06/07/24 at 3:06 PM. He stated that the Maintenance Director had spoken to him this week about flies, but 'we had not identified the issue at the level" identified by the surveyor. He stated that they had recently replaced all the screens in the resident room windows. The Administrator stated he had spoken

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 925	Continued From page 160 to the residents in Room 308 and asked them about the flies and they thought the flies were present because of the temperature in the room and he offered to turn the air conditioning up and they declined. He stated that he asked them to move rooms temporarily so the room could be deep cleaned, and they consented.	F 925		