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	345179	A. BUILDING _____ B. WING _____	C 07/22/2024

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 000	INITIAL COMMENTS An unannounced complaint investigation was conducted from 07/18/24 through 07/19/24 with additional information obtained on 07/22/24. Therefore the exit date was changed to 07/22/24. The following intakes were investigated: NC00218631, NC00218660, NC00218735 and NC00219262. 1 of the 8 allegations resulted in a deficiency. Event ID #LESM11.	F 000		
F 600 SS=G	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 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, staff and Resident interviews the facility failed to protect a resident's (Resident #1) right to be free from abuse for 1 of 2 residents reviewed for abuse. Resident #2 was observed to cover Resident #1's mouth with his hand and pinch her nose using his thumb and index finger preventing her from breathing and causing her face to turn bright red and causing her to cry. Resident #1 stated she was afraid of	F 600	The facility will complete an initial and 5-day investigation report related to the event that occurred on 6/28/24 involving Resident #1 and Resident #2 and fax it to the state by 8/12/24. The current residents are at risk for this deficient practice. The facility will complete an audit of the facility's risk events to include residents'	8/13/24

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

Electronically Signed | 08/08/2024

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F 600	Continued From page 1 Resident #2. The finding included: Resident #1 was admitted to the facility on 09/12/17 with diagnoses that included traumatic spinal cord dysfunction, anoxic brain injury and paraplegia (paralysis which can result from a spinal cord injury which can affect all or part of the trunk, legs and pelvic organs). Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated 06/20/24 revealed Resident #1 was cognitively intact and required set up to dependent level of assistance from staff with most of her activities of daily (ADL). The care plan revised on 09/28/23 revealed Resident #1 had an ADL self-care deficit performance related to anoxic brain injury, paraplegia and physical limitations. Resident #2 was admitted to the facility on 01/16/24 with diagnoses that included heart failure, diabetes mellitus. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 05/13/24 revealed Resident #2's was cognitively intact, and no behaviors indicated on the MDS. The MDS also indicated the Resident required independent to dependent assistance from staff for his activities of daily living. The care plan revised 05/21/24 revealed Resident #2 had an ADL self-care deficit performance related to weakness, respiratory failure. The goal that Resident #2 would improve in his ADL function would be attained by utilizing	F 600	progress notes in the last 60 days to ensure that residents remain free of abuse, neglect, misappropriation of resident property, and exploitation by 8/12/24. Any identified events will be investigated and reported to the state. The Administrator, the Director of Nursing and the Chief Nursing Officer were educated on 7/24/24 by an outside consulting firm on abuse, neglect, misappropriation of resident property and exploitation to include the reporting guidelines, timely reporting and completing a thorough investigation. New hire and contract Administrators and Directors of Nursing will not be allowed to work prior to completing this education. Starting 7/24/24, the outside consultant and/or the staff development coordinator (SDC) educated the facility staff to include licensed nurses, certified nursing assistants, certified medication aides, therapy, housekeeping, dietary, social services, maintenance, activities and administrative staff on abuse, neglect, misappropriation of resident property and exploitation to include timely reporting to facility administration. After 8/12/24, facility staff, new hires, prn and agency staff will not be allowed to work until the education is completed. The Director of Nursing will complete audits of resident risk events and progress notes weekly x 12 weeks and monthly x 3 months to ensure residents remain free from abuse, neglect and exploitation and any identified events are reported timely, investigated and required reports are being sent to the state. The	

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F 600	Continued From page 2 interventions that included providing limited to extensive assistance from staff to perform ADLs. Review of a nurse progress note written by Nurse #1 dated 06/28/24 at 7:41 PM revealed during report with Nurse #2, writer watched Resident #1 and Resident #2 sitting by the nurses' cart face to face. Resident #2 began to cover Resident #1's mouth with his left hand and pinch her nose closed with his thumb and index finger. Nurse #1 alerted Nurse #2 to turn around and observe what Resident #2 was doing to Resident #1. Both Nurses witnessed Resident #1's color begin to change, and Resident #1 looked up at both Nurse #1 and Nurse #2 for help. Resident #2 let go and began to force his thumb vigorously and deep into Resident #1's mouth. Nurse #2 interfered and asked Resident #1 if she was okay. A few minutes later Resident #1 began to cry, and Resident #2 wiped her tears away. Resident #1 was removed from the situation and placed into bed. An interview was conducted with Nurse #1 on 07/22/24 at 9:20 AM who explained that she was on duty during the day of 06/28/24 and noticed that Resident #1 and Resident #2 were together all during the shift sitting in the hallway together holding hands and thought that was their normal routine. The Nurse explained that the night of 06/28/24 during shift change, she and Nurse #2 were standing at the medication cart giving shift report when she observed Resident #2 reach up with hand and cover her mouth. Resident #1's eyes began to roll back while she was looking at the two nurses standing close by. Nurse #1 stated Resident #2 then released his grip then pinched Resident #1's nose closed using his thumb and index finger after which Resident #1's	F 600	findings of the audits will be reported in the Quality Improvement Performance Committee meeting for review and revision as needed x 6 months.	

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F 600	Continued From page 3	F 600		

face started to turn red, and her head fell backwards. Nurse #1 continued to explain that she alerted Nurse #2 who was closer to the two residents to see what was happening and when she alerted Nurse #2, Resident #2 removed his hand from Resident #1's mouth and started to force his thumb in her mouth and by that time Nurse #2 had reached the two residents. She stated the whole encounter happened in a matter of about 20 seconds. Nurse #1 continued to explain that Nurse #2 immediately removed Resident #1 from Resident #2 and asked her if she was okay when Resident #2 answered her that Resident #1 was okay. Nurse #1 described the look on Resident #1's face during the incident as fright.

Review of a nurse progress note written by Nurse #2 dated 06/28/24 at 10:50 PM revealed a late entry note that revealed Nurse #2 observed Resident #2 pressing his hand against Resident #1's face, covering up her nose and mouth which appeared to cause Resident #1's face to become red and flushed. Nurse #2 asked Resident #2 what he was doing, and he removed his hand off Resident #1's face. Asked Resident #1 if she was, okay? As staff began moving Resident #1's wheelchair away, Resident #2 stated to Resident #1 "tell them you're okay" two times quickly. Resident #1 gave Resident #2 a blank stare then stated "I'm okay" as a few tears rolled down her face. The Residents were separated. Resident #1's vital signs and skin check was completed (in the Resident's room). Resident #1 was placed in her bed and as she was transferred to bed Resident #1 stated "I am scared of him, but I love him". Informed Resident #1 that management was involved and has worked out a plan to keep her safe. Resident #1 smiled and appeared to be

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F 600	Continued From page 4	F 600		

relieved and calm stating "thank you for caring about me".

Interviews were conducted with Nurse #2 on 07/18/24 at 4:45 PM and 07/18/24 at 8:40 PM. Nurse #2 explained that during shift change report on the evening of 06/28/24 she was receiving report from Nurse #1 while standing by the medication cart in the hallway. The Nurse stated that Nurse #1 told her to turn around and look at what Resident #2 was doing to Resident #1 who were sitting in their wheelchairs in the hallway directly behind her. Nurse #2 reported that she observed Resident #2's hand over Resident #1's mouth with his thumb and index finger pinching Resident #1's nose and appeared to be pushing Resident #1's head back. Resident #1's head was leaning to the left and there was a pillow behind her head for support. Nurse #2 continued to explain that Resident #1's face was bright red, and her eyes were rolled to the top of her eyelids. The Nurse rushed to the two residents and stated to Resident #2 "what are you doing" and Resident #2 slowly moved his hand off her face as if he was in a trance. Nurse #2 reported she then moved Resident #1 away from Resident #2 and asked Resident #1 if she was okay and as she moved the Resident, she gave Nurse #2 a look like Resident #1 was in shock. The Nurse stated as she was moving Resident #1 away from Resident #2, Resident #2 stated to Resident #1 to "tell them that you are okay" twice while being wheeled to her room. The Nurse continued to explain that after Resident #1 was taken to her room and put to bed Nurse #2 assured the Resident that she was safe, and she would not have to have any contact with Resident #2 that night. The Nurse reported Resident #1 never stated Resident #2 was trying to hurt her,

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F 600	Continued From page 5	F 600		

but Resident #1 did say that she was afraid of him and did not want to make him mad. Nurse #2 explained that as she was assessing Resident #1's vital signs and performed a skin check she assured Resident #1 again that she was safe, and tears began to roll down the Resident's face. The Nurse stated Resident #1 was okay but that she appeared to be in shock because the Resident seemed just as surprised at what happened as the staff were. Nurse #2 reported she called the Director of Nursing (DON), the Administrator, the on-call provider and Resident #1's representative and informed them of what happened. She stated the Administrator had her repeat the incident twice and instructed her to put Resident #2 on a one-on-one observation until Monday 07/01/24 and for Resident #2 not to have any contact with Resident #1. Nurse #2 revealed Resident #1 and Resident #2 were a couple and in a relationship in that they were with each other all the time like sitting in the hallway and in rooms together. She stated they were in each other's faces all the time but that she had never seen anything abnormal between the two before the incident on 06/28/24.

An interview was conducted with Resident #1 on 07/18/24 at 1:25 PM. The Resident was sitting in her wheelchair in her room with her head leaning to her left almost resting on her left shoulder. The Resident was asked about the incident on the evening of 06/28/24 and Resident #1 acknowledged she was aware of the incident in question. Resident #1 explained that she and Resident #2 were sitting in the hallway and Resident #2 put his hand over her mouth and put his finger in her mouth for her to hold and suck on, which she did often. Resident #1 continued to explain that she did not know that Resident #2

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F 600	Continued From page 6	F 600		

was going to put his finger in her mouth at that time but that in doing so, he did not hurt her. She indicated that she did not mind Resident #2 putting his finger in her mouth and that she liked it. The Resident stated she often let Resident #2 put his finger in her mouth and she held it there because she wanted him to. When asked directly if Resident #2 pinched her nose during the incident on the evening of 06/28/24 the Resident stated that she did not remember that part nor did she remember it making her cry. She stated she loved Resident #2 and had plans to marry him.

On 07/18/24 at 3:50 PM during an interview with Resident #2 about the incident documented on the evening of 06/28/24 the Resident explained that he and Resident #1 were sitting in the hallway, and he blacked out and when he came to his hand was up on Resident #1's mouth. The Resident stated the staff asked him if Resident #1 was okay and he told them yes. Resident #2 continued to explain that the staff told him that he put his hand up over Resident #1's nose, but he did not know it. He insisted his hand was not on her nose before he blacked out. Resident #2 stated the staff took Resident #1 to her room and did not allow him to see or speak to Resident #1 for several days.

During an interview with the Director of Nursing (DON) on 07/18/24 at 2:30 PM the DON explained that she was informed about the incident between Resident #1 and Resident #2 the night of 06/28/24 after it happened and instructed Nurse #2 to remove Resident #1 away from Resident #2 and provide safety for the Resident which the Nurse did. She also instructed the Nurse to obtain Resident #1's vital signs and conduct a complete head to toe assessment

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F 600	Continued From page 7 (which she had already completed) and to notify the on-call provider and Resident #1's representative. The DON stated she instructed Nurse #2 to notify the Administrator of the incident and follow his directions. The DON reported that Resident #1 and Resident #2 was a couple and in a "relationship" since about January 2024 shortly after Resident #2 was admitted to the facility and spent a lot of time together but nothing like the incident on 06/28/24 had been reported. An interview was conducted with the Administrator on 07/19/24 at 12:25 PM. The Administrator explained that Nurse #2 called him the night of 06/28/24 and reported that Nurse #1 reported that she observed Resident #2's hand over Resident #1's mouth and they had separated them and took Resident #1 to her room. The Nurse reported that Resident #2 was not happy about Resident #1 being separated from him and wanted to see Resident #1, but the Administrator told the Nurse to put Resident #2 on one-to-one observation until he had a chance to evaluate the situation. The Administrator stated that the way the incident was described to him by Nurse #2 that he felt the situation was questionable and did not think of it as abuse.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		8/13/24

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F 607	Continued From page 8 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy in the areas of reporting and investigating. When there was an allegation of abuse, an initial report was not submitted to the State Agency, a 5 day investigation was not submitted to the State Agency, law enforcement and Adult Protective Services (APS) were not notified for 1 of 2 residents reviewed for abuse (Resident # 1). The finding included: The facility's policy titled, "Abuse, Neglect and Exploitation", revised 10/22/23 read in part, ""It is the policy of this facility to provide protections for	F 607	The facility will complete an initial and 5-day investigation report related to the event that occurred on 6/28/24 involving Resident #1 and Resident #2 to include notifying the law enforcement and Adult Protective Services and faxing it to the state by 8/12/24. The current residents are at risk for this deficient practice. The facility will complete an audit of the facility's risk events to include residents' progress notes in the last 60 days to ensure any identified allegations of abuse are reported and investigated to include that initial and 5-day investigations have	

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F 607	Continued From page 9 the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include identifying staff responsible for investigation; identifying and interviewing all persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause; providing complete and thorough documentation of the investigation. The facility will have written procedures that include: reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e.g., law enforcement when applicable within specified timeframes: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse and result in serious bodily injury or b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury; and assuring that reporters are free from retaliation or reprisal." An interview was conducted with Nurse #1 on 07/22/24 at 9:20 AM who explained that she was on duty during the day of 06/28/24 and noticed that Resident #1 and Resident #2 were together all during the shift sitting in the hallway together holding hands and thought that was their normal routine. The Nurse explained that the night of 06/28/24 during shift change, she and Nurse #2	F 607	been submitted to the State Agency and law enforcement and Adult Protective Services were notified by 8/12/24. The Administrator, the Director of Nursing and the Chief Nursing Officer were educated on 7/24/24 by an outside consulting firm on abuse, neglect, misappropriation of resident property and exploitation to include the reporting guidelines, timely reporting, completing a thorough investigation and notification of law enforcement and Adult Protective Services. New hire and contract Administrators and Directors of Nursing will not be allowed to work prior to completing this education. Starting 7/24/24, the outside consultant and/or the staff development coordinator (SDC) educated the facility staff to include licensed nurses, certified nursing assistants, certified medication aides, therapy, housekeeping, dietary, social services, maintenance, activities and administrative staff on abuse, neglect, misappropriation of resident property and exploitation to include timely reporting to facility administration. After 8/12/24, facility staff, new hires, prn and agency staff will not be allowed to work until the education is completed. The Director of Nursing will complete audits of resident risk events and progress notes weekly x 12 weeks and monthly x 3 months to ensure that when there are allegations of abuse are identifed initial and 5 day reports are being submitted and law enforcement and Adult Protective Services are notified. The findings of the audits will be reported	

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F 607	Continued From page 10 were standing at the medication cart giving shift report when she observed Resident #2 reach up with his hand and cover her mouth. Resident #1's eyes began to roll back while she was looking at the two nurses standing close by. Nurse #1 stated Resident #2 then released his grip then pinched Resident #1's nose closed using his thumb and index finger after which Resident #1's face started to turn red, and her head fell backwards. Nurse #1 continued to explain that she alerted Nurse #2 who was closer to the two residents to see what was happening and when she alerted Nurse #2, Resident #2 removed his hand from Resident #1's mouth and started to force his thumb in her mouth and by that time Nurse #2 had reached the two residents. She stated the whole encounter happened in a matter of about 20 seconds. Nurse #1 continued to explain that Nurse #2 immediately removed Resident #1 from Resident #2 and asked her if she was okay when Resident #2 answered her that Resident #1 was okay. Nurse #1 described the look on Resident #1's face during the incident as fright. Interviews were conducted with Nurse #2 on 07/18/24 at 4:45 PM and 07/18/24 at 8:40 PM. Nurse #2 explained that during shift change report on the evening of 06/28/24 she was receiving report from Nurse #1 while standing by the medication cart in the hallway. The Nurse stated that Nurse #1 told her to turn around and look at what Resident #2 was doing to Resident #1 who were sitting in their wheelchairs in the hallway directly behind her. Nurse #2 reported that she observed Resident #2's hand over Resident #1's mouth with his thumb and index finger pinching Resident #1's nose and appeared to be pushing Resident #1's head back. Resident	F 607	in the Quality Improvement Performance Committee meeting for review and revision as needed x 6 months.	

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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
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#1's head was leaning to the left and there was a pillow behind her head for support. Nurse #2 continued to explain that Resident #1's face was bright red, and her eyes were rolled to the top of her eyelids. The Nurse rushed to the two residents and stated to Resident #2 "what are you doing" and Resident #2 slowly moved his hand off her face as if he was in a trance. Nurse #2 reported she then moved Resident #1 away from Resident #2 and asked Resident #1 if she was okay and as she moved the Resident, she gave Nurse #2 a look like Resident #1 was in shock. The Nurse stated as she was moving Resident #1 away from Resident #2, Resident #2 stated to Resident #1 to "tell them that you are okay" twice while being wheeled to her room. The Nurse continued to explain that after Resident #1 was taken to her room and put to bed Nurse #2 assured the Resident that she was safe, and she would not have to have any contact with Resident #2 that night. The Nurse reported Resident #1 never stated Resident #2 was trying to hurt her, but Resident #1 did say that she was afraid of him and did not want to make him mad. Nurse #2 explained that as she was assessing Resident #1's vital signs and performed a skin check she assured Resident #1 again that she was safe, and tears began to roll down the Resident's face. The Nurse stated Resident #1 was okay but that she appeared to be in shock because the Resident seemed just as surprised at what happened as the staff were. Nurse #2 reported she called the Director of Nursing (DON), the Administrator, the on-call provider and Resident #1's representative and informed them of what happened. She stated the Administrator had her repeat the incident twice and instructed her to put Resident #2 on a one-on-one observation until Monday 07/01/24 and for Resident #2 not to have

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 07/22/2024

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any contact with Resident #1. Nurse #2 revealed Resident #1 and Resident #2 were a couple and in a relationship in that they were with each other all the time like sitting in the hallway and in rooms together. She stated they were in each other's faces all the time but that she had never seen anything abnormal between the two before the incident on 06/28/24.

An interview was conducted with the Administrator on 07/19/24 at 12:25 PM. The Administrator explained that Nurse #2 called him the night of 06/28/24 and reported that Nurse #1 reported that she observed Resident #2's hand over Resident #1's mouth and they had separated them and took Resident #1 to her room. The Nurse reported that Resident #2 was not happy about Resident #1 being separated from him and wanted to see Resident #1, but the Administrator told the Nurse to put Resident #2 on one-to-one observation until he had a chance to evaluate the situation. The Administrator stated that the way the incident was described to him by Nurse #2 that he felt the situation was questionable and did not think of it as abuse. The Administrator indicated that in retrospect he should have perceived the incident as abuse and followed the facility's abuse policy and procedures by submitting an initial and 5-day investigation report to the state agency and he should have notified adult protective services and local law enforcement.