STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/29/25 through 1/31/25. Event ID# UWBI11. The following intakes were investigated NC00220677, NC00226295, NC00225879, NC00224893, NC00221266, NC00214768, and NC00212829. 2 of the 13 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to protect a resident from misappropriation when his debit card was used while he was hospitalized. This was for 1 of 3 residents reviewed for misappropriation (Resident #3). The findings included: Resident #3 was admitted to the facility 4/4/24 with diagnoses including lung disease and heart failure. The quarterly Minimum Data Set (MDS) assessment dated 11/14/24 assessed Resident	F 602	(1) How corrective action will be accomplished for resident(s) found to have been affected: The police were notified by the Administrator regarding Resident #3s credit/debit card was missing and fraudulent charges were made as reported by the guardian. Resident #2, the roommate was interviewed by the police and the Director of Nursing on 12/4/24, regarding misappropriation. The police could not prove that the credit card was stolen. (2) How corrective action will be	1/31/25

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

Electronically Signed | 02/21/2025

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F 602	Continued From page 1 #3 to be severely cognitively impaired. Resident #3 did not have any behaviors noted on the MDS assessment. A nursing note dated 11/26/24 documented Resident #3 was sent to the hospital for evaluation after a change in status. A note dated 12/4/24 documented Resident #3 died at the hospital on 12/4/24. Resident #3's bank statement dated 12/18/24 documented debit card used from 11/27/24 to 12/4/24 totaling $157.92. The bank statement indicated 70 transactions had been completed from 11/27 to 12/4/24 and all but one transaction had been conducted at a vending machine. A transaction dated 12/3/24 was for a pizza delivery. Resident #3's guardian was interviewed by phone on 1/30/25 at 11:21 AM. The guardian reported upon Resident #3's death, she ran a bank statement report to review his account. The guardian reported she discovered the debit card had been used multiple times per day during his hospitalization and on the day he died. The guardian reported she and the facility searched Resident #3's room and they were unable to find the missing debit card. The guardian reported the facility would not reimburse the debit card charges and told her to talk to the bank. The guardian explained she had Power of Attorney for Resident #3 until his death and then the responsibility of the finances was to be turned over to his Next of Kin, but she felt it was important to have the money reimbursed to the debit card. The Director of Nursing (DON) was interviewed	F 602	accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 12/4/24, the Administrator, The Director of Nursing, initiated resident and staff interviews to all residents that can be interviewed to see if any other residents had been affected by the alleged suspect or anyone else and who to report to if ever affected by misappropriation. No other residents were noted to be affected. On 12/5/24, the Administrator reviewed resident rights with a focus on misappropriation with the residents and staff that included definition review and who to report to if ever affected by misappropriation. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 12/5/24, the Administrator, Director of Nursing, initiated re-education to all staff regarding misappropriation that includes the process for reporting loss of debit/credit cards and/or unauthorized purchases/charges, the definition of misappropriation, exploitation, examples of resident property, examples of misappropriation, and signs to look for that could signify misappropriation. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:	

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F 602	Continued From page 2 on 1/30/25 at 11:16 AM. The DON explained that on 12/4/24 Resident #3's guardian came to the facility to notify the facility Resident #3 had died at the hospital and that she had discovered activity on his debit card during his hospitalization. The DON explained Resident #3's room was searched, and the debit card could not be located. The guardian reported $157.92 was used on the debit card, and she brought in the bank statements to review with the facility. The DON reported they did not know who ordered the pizza delivery, but pizza was delivered from the business on the bank statement to the facility on 12/3/24. The DON described completing the report and conducting the investigation by reviewing the camera footage from the living room with the vending machines as well as interviewing staff and residents, including Resident #2. The DON reported they were unable to identify any staff or residents using Resident #3's debit card from the camera footage. The DON said that the police were called, and the officer conducted interviews with Resident #2 and staff and was unable to determine if the debit card was taken. The DON reported the facility had not reimbursed Resident #3's guardian for the debit card charges and reported that would be the bank's responsibility. Resident #2 was interviewed on 1/30/24 at 11:00 AM. Resident #2 reported he was Resident #3's roommate and he was not aware of the missing debit card until he was interviewed by police. Resident #2 was not certain which date the police interviewed him, but reported it was in December 2024. Resident #2 reported he had not used Resident #3's debit card to obtain snacks from the vending machine or order pizza.	F 602	Starting 2/24/2025, monitoring will be done by the Administrator, The Director of Nursing, or designee to ensure that through the grievance process and resident interviews, no additional occurrences of misappropriation take place. This monitoring process will consist of 5 resident interviews weekly for 4 weeks and then 10 resident interviews monthly for 3 months. Any issues during monitoring will be addressed immediately. The Administrator and/or The Director of Nursing will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 602	Continued From page 3 The Administrator was interviewed on 1/30/25 at 2:32 PM and she reported Resident #3 had a lock box in his room and his wallet was in the lock box, but the debit card was not found. The Administrator explained that Resident #2 was interviewed, and he denied knowing the debit card was missing, and denied using the debit card. The Administrator reported the police were notified and they interviewed Resident #2 and staff members, and the police told the facility there was nothing else that could be done. The police could not prove the debit card was stolen. A follow-up interview was conducted with the Administrator on 1/31/25 at 1:45 PM. The Administrator explained that the bank did reimburse the debit card for the charges and the facility did not reimburse the charges. The Administrator explained the guardian did not want to press charges against Resident #2. The Administrator reported she expected there was no misappropriation of resident property, but if it did happen, it was reported according to the regulations.	F 602		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		2/21/25

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F 686	Continued From page 4 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and Wound Physician Assistant, Physician, and staff interviews, the facility failed to change a pressure ulcer dressing according to physician orders for 1 of 3 residents reviewed for pressure ulcer care (Resident #6). The findings included: Resident #6 was admitted to the facility on 10/9/24 with diagnoses including pressure ulcer and hypertension. The quarterly Minimum Data Set assessment dated 12/9/24 documented Resident #6 was severely cognitively impaired, and she had one Stage 4 pressure ulcer on admission. Wound care orders for Resident #6 were reviewed and an order dated 1/24/25 specified wound care was to be provided daily: cleanse with normal saline or wound cleanser, pack with packing strip wet with sodium hypochlorite (an antiseptic wound treatment), cover with absorbent dressing. Review of Resident #6's Treatment Administration Record revealed no nurse initials for 1/28/25 that indicated the wound care had been completed that date for the Stage 4 pressure ulcer. An observation of wound care was conducted on 1/29/25 at 12:17 PM with the Wound Care Nurse and the Wound Care Physician Assistant. The	F 686	For affected resident(s): Resident #6 pressure ulcer treatments were completed on 1/29/25 as per MD order. For other residents with the potential to be affected: All the residents with a pressure or non-pressure wound who reside in the facility has the potential to be affected by this deficient practice. Audit on 2/17/25 revealed that there were not any additional residents affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. Measures put into place/System changes made to ensure that the identified issue does not re-occur: To protect residents from similar occurrences, on 2/17/25, the Director of Nursing, and the Supervisor initiated re-educated to the licensed nurses regarding the completion of pressure ulcer treatments as ordered. The Director of Nursing educated the wound nurse to complete all her pressure and non-pressure wounds daily. The DON or designee will in-service all the nursing staff to complete all wounds on their assignment in the absence of a designated wound nurse. Director of Nursing or designee will conduct audits as	

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F 686	Continued From page 5	F 686		

pressure ulcer dressing in place on Resident #6 was noted to be dated 1/27/25. During the observation, Resident #6 was asked if the wound care was provided the previous day on 1/28/25 and Resident #6 reported it was not completed.

The Wound Care Nurse was interviewed during the observation, and she revealed she had left work early on 1/28/25 and did not complete the wound care for Resident #6. The Wound Care Nurse explained that when she was not working, the nurse assigned to the hall was responsible for wound care dressing.

The Wound Care Physician Assistant was interviewed on 1/29/25 at 12:28 PM and he reported Resident #6's wound measurements had decreased, and the wound was improving. The Wound Care Physician Assistant reported the one missed dressing change had not negatively affected Resident #6.

The Unit Manager was interviewed on 1/29/25 at 12:33 PM. The Unit Manager explained the Wound Care Nurse had left early on 1/28/25 and the nurse assigned to the hall should have completed the wound care. The Unit Manager reported she was not aware Resident #6's wound care had not been provided on 1/28/25.

Nurse #1 was interviewed by phone on 1/30/25 at 9:08 AM. Nurse #1 explained she was an agency nurse, and she had been to the facility a few times before 1/28/25. Nurse #1 reported she was assigned to Resident #6 on 1/28/25. Nurse #6 reported she had been told the Wound Care Nurse would complete all wound care for the residents on her assigned hall, and she was not aware the wound care nurse had left early on

outlined below.

How the corrective actions will be monitored:
A monitor sheet will be done by the DON, or designee to monitor and ensure that all pressure ulcer treatments as ordered are completed by observation and verification form the treatment administration record. The Director of Nursing or designee will ensure that all the pressure and non-pressure wounds will be done daily as well as by MDs orders by auditing the EMARs daily x 2 weeks, weekly x 2 and monthly x 2.

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F 686	Continued From page 6	F 686		

1/28/25. Nurse #1 explained if she had been aware, she would have provided the wound care to Resident #6.

The Wound Care Nurse was interviewed again on 1/30/25 at 10:51 AM and she reported she had left early on 1/28/25 and the Unit Manager and Director of Nursing were aware she was leaving early. The Wound Care Nurse reported she was not aware the wound care for Resident #6 had not been completed until it was observed during wound care on 1/29/25.

The Physician was interviewed by phone on 1/31/25 at 10:22 AM. The Physician reported he had been notified of the missed wound care for Resident #6 when the facility discovered it and he was in agreement with the Wound Care Physician Assistant that the missed wound care had not adversely affected Resident #6.

The Director of Nursing was interviewed by phone on 1/31/25 at 11:59 AM and she reported she was aware the Wound Care Nurse left early on 1/28/25 and Nurse #1 should have been notified she was expected to complete wound care. The Director of Nursing explained wound care was expected to be completed according to physician orders.

The Administrator was interviewed by phone on 1/31/25 at 1:45 PM and she reported the Wound Care Nurse left early on 1/28/25 and Nurse #1 should have been told she needed to complete wound care. The Administrator explained there was a lot of activity on that date and Nurse #1 may not have been told she needed to complete wound care. The Administrator reported she expected wound care to be completed according

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F 686	Continued From page 7 to physician orders.	F 686		