PRINTED: 09/01/2022 FORM APPROVED OMB NO. 0938-0391

	CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE COMP	
		345130	B. WING _			07/:	29/2022
	ROVIDER OR SUPPLIER  JS HEALTH AT CONCOR	RD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		• • • • • • • • • • • • • • • • • • • •	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	was conducted on 7/2 found to be in compliar related to E-0024 (b)(for Long Term Care FINITIAL COMMENTS)  A complaint survey w 7/25/2022 through 7/2 Jeopardy was identified CFR 483.10 at tag F5 (J)  CFR 483.45 at tag F7 (J)  The tag F760 constitutions.  Immediate Jeopardy I was removed on 7/29 survey was conducted 7 of the 43 complaint substantiated resulting Intakes investigated: NC00188314 NC00189422 NC00189478 NC00190166 NC00190323 NC00191085	vas conducted from 29/2022. Immediate ed at: 680 at a scope and severity valued Substandard Quality of began on 3/18/2022 and 1/2022. An partial extended d. allegations were	FO	00			
	NC00191167 NC00191142 NC00191143 NC00191253 NC00191310	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE			(X6) DATE

Electronically Signed 08/16/2022

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345130	B. WING				C <b>29/2022</b>
	ROVIDER OR SUPPLIER	RD		5	STREET ADDRESS, CITY, STATE, ZIP CODE 115 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580 SS=J	CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must immonsult with the residuconsistent with his or representative(s) when the consistent chan mental, or psychosoci deterioration in health status in either life-the clinical complications (C) A need to alter the a need to discontinue treatment due to advect commence a new form (D) A decision to transport the commence and the commence in the commence of the commence in the commence of the	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or a); reatment significantly (that is, an existing form of erse consequences, or to an of treatment); or effer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the elso promptly notify the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or as as specified in paragraph . ecord and periodically mailing and email) and	F	580			7/29/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		345130	B. WING			C 7/ <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE	•	1772972022
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	that is a composite di	osite distinct part. A facility stinct part (as defined in	F 58	30		
	its physical configura locations that comprispart, and must specific room changes between under §483.15(c)(9). This REQUIREMENT by:  Based on observation resident, staff, physicathe facility failed to nowhen two doses of all (anti-seizure) medical administer on 03/18/2 episodes of seizure all hospitalizations to co 03/19/22-03/21/22 and mospitalizations to co 03/19/22-03/21/22 and must specific part of the comprision of th	ian and neurologist interview otify a Resident's Physician		This constitutes a written alleg compliance. Preparation and submission of this allegation of compliance does not constitute admission or agreement by the the truth of the facts alleged or correctness of the conclusion of the statement of deficiencies. allegation of compliance is presubmitted solely because of reunder state and federal law, ar	e an e provider of the set forth on This pared and quirement	
	Immediate Jeopardy facility failed to admir anti-convulsant media Physician that the me Resident #1 had two and required hospital 03/24/22. Immediate 07/29/22 when the faimplemented an accellimediate Jeopardy remain out of complia severity level D (no a more that minimal ha	edication was not available. episodes of seizure activity ization on 03/19/22 and Jeopardy was removed on cility provided and eptable credible allegation of removal. The facility will ance at a lower scope and ctual harm with potential for rm that is not immediate the deficient practice and		demonstrate the good faith atte the provider to continue to implicate the provider of the provider of the provider to continue to con	empts by rove the have a serious f the om the an audit on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING		C <b>07/29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/20/2022
				515 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
F 580	Continued From pag	e 3	F 580		
	remove the immediat	te jeopardy are effective.		Records of current residents receiving	-
	Findings included:			anti-seizure medications and validate these medications have been administered during the last 7 days.	
	Resident #1 was adn	nitted to the facility on		Medication error report will be complete	
		ses that included Sialidosis		by the Nurse Managers for any missi	
	(a hereditary disorde	r that causes impaired vision		documentation and the Physician not	ified
	and coordination), ep myoclonus (muscle t	oilepsy (seizure disorder) and witching).		immediately.	
				Specify the action the entity will take	e to
		Resident #1 indicated the		alter the process or system failure to	
		cation Brivaracetam tablet		prevent a serious adverse outcome fr	om
		s ordered two times a day disorder) on 02/11/22.		occurring or recurring, and when the action will be complete	
		Medication Administration		Nurse Managers will re-educate licen	
	' '	led Resident #1 did not s on 03/18/22 due to the		nurses, including agency staff, regard	ling
	medication not being			the facility's policy for notifying the Physician to include notification relate	ed to
	medication not being	available.		physician ordered anti-seizure	,4 10
	Record review of the	MAR for the Brivaracetam		medications that are unavailable for	
	administration for 03/	/18/22 indicated Nurse #2		administration. The Director of Nursin	g
	_	AM dose and Nurse #1		will ensure no staff will work without	
		ne 8:00 PM dose to Resident		receiving this education. Any new h	ires,
	#1.			including agency staff will receive education prior to the start of their shi	<b>f</b>
	Review of the Medica	ation Administration Record		Education will be completed by 7/28/2	
		t1 for the 03/18/22 8:00 AM		the Nurse Managers.	-L U
	` '	oted '9-other', and Nurse #2		9	
		on pharmacy delivery.'		The Regional Director of Clinical Serv	vices
				educated the Director of Nursing, Nur	
	· ·	as conducted on 07/27/22 at		Managers and the Administrator rega	-
		#2 regarding the 03/18/22		the clinical morning meeting process	
	8:00 AM Brivaraceta			include a review of residents receiving	g
		ysician notification. She did		anti-seizure medications to validate	
		1 or the missing medication id if she did not have the		documentation of notification to the physician related to ordered anti-seiz	ıre
		ster, she would have called		medications unavailable for	uic
		ure they had the order.		administration. This education was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345130	B. WING			C <b>7/29/2022</b>
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		112912022
	10 11 D L 11 0 11 0 0 1 1 L 1 L 11			515 LAKE CONCORD ROAD NE	-	
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
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F 580	Continued From pag	e 4	F 58	30		
		e pharmacy was sending the ld not have called the doctor.		completed on 7/28/22.		
		recall notifying any Provider.		Effective 7/28/2022 the Admin	istrator will	
		d only call the doctor if the		be responsible to ensure imple	ementation	
	medication was not o	on its way or if it needed a		of this immediate jeopardy ren	noval for	
	new prescription.			this alleged non-compliance		
				Alleged Date of IJ Removal: 7	/28/2022	
		MAR revealed for the				
	03/18/22 8:00 PM Br			Resident #1 was discharged fi	rom the	
		#1 had documented at 10:41		facility on 3/24/2022.		
		noted: "9-other, in route from		Nivers Managers assembleted as		
		ritals all within normal limits."		Nurse Managers completed at 7/28/22 of the Medication Adm	ninistration	
	A phone interview was 12:08 PM with Nurse	as conducted on 07/28/22 at e #1 that had not		Records of current residents re anti-seizure medications and v	-	
		varacetam medication on for Resident #1 regarding		these medications have been administered during the last 7	days. A	
	physician notification			Medication error report was be	•	
		available, I had checked with		by the Nurse Managers for an		
		d she was talking "generally		documentation and the Physic		
		the event." Nurse #1 noted		immediately. Initial audit of re		
		ving would have been to call		ordered anti-seizure medication no irregularities and no medication		
		, and usually she would let he expected time of arrival.		reports were required as a res		
		dicine was an issue. She		audit.	uit or triis	
		er medical record note was-		addit.		
		from pharmacy.' Nurse #1		The Regional Director of Clinic	cal Services	
	stated she "would ha			educated the Director of Nursi		
	physician and she di	d not know why this		Managers and the Administrat		
	documentation was r	not there, but no one told me		the clinical morning meeting p	rocess to	
	to call the physician	from the facility and she can't		include a review of residents r	eceiving	
	explain why she did	not document it."		anti-seizure medications to va		
				documentation of administration		
		ated on 03/19/22 the resident		medications as ordered by the		
	_	35 minutes. Emergency		Education was completed on 7	//28/2022.	
	Medical Services (EN			Linemand more as the short	anav ata#	
		ses intravenously (IV) of the		Licensed nurses, including ag	-	
		enroute to the hospital. spitalized until 03/21/22.		were educated regarding the poblaining an ordered medication		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDIN				(X3) DATE SURVEY COMPLETED		
		345130	B. WING			C 07/29/2022
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0172072022
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	ORD		CONCORD, NC 28025		
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
F 580	Continued From pag	ge 5	F 58			
	D : (!! MAD:			unavailable for administration, in	•	
		indicated Resident #1		contacting the pharmacy to obtain		
		tions as ordered twice daily		medication, notification of the ph	•	
	upon return from the PM-03/23/22 8:00 PI	hospital on 03/21/22 8:00		and documentation of such. Edu		
	FIVI-U3/23/22 0.00 FI	IVI.		was completed by 7/28/22. Eduction continue with newly hired license		
	Record review noted	d on 03/24/22, Resident #1		and/or agency staff prior to the s		
		for 20 minutes. EMS was		work.	tart or	
		ed IV Midazolam by EMS and		Werk.		
	was transported to th	<del>-</del>		Nurse Managers and/or designe	e will	
	•	•		complete an audit of the medicat	tion carts	
	The Neurologist was	interviewed via phone on		weekly on Thursdays to validate	seizure	
	7/27/22 at 12:46 PM	regarding Resident #1. He		medications are available for		
		n Brivaracetam were being		administration and needs identifi		
	used for his myoclon	,		corrected. Findings will be docu	mented	
		the nurses needed to be		on the appropriate audit tool.	_	
		ortance of giving medications		During regularly scheduled clinic		
		ining the medications. The		meetings on Monday – Friday, N		
	_	nurse should have called		Managers will review Medication		
		n was not available. The he would have been called,		Administration Records (MARs) residents on anti-seizure medica		
	_	d a local pharmacy if the		ensure that anti-seizure medication		
		ould not provide it. The		available since the day of the pre		
		then he did not receive the		audit and that anti-seizure medic		
	•	ed the resident harm and he		have been administered as orde		
	had breakthrough se			physician and that the appropria	-	
	, and the second			measures were taking if medicat		
	A follow up phone in	terview with the Neurologist		unable to be administered as ord	dered.	
		7/27/22 at 4:51 PM regarding		Beginning on 7/29/2022, audits v		
		acetam doses that were not		completed five (5) times weekly		
		18/22. He stated when the		period of four (4) weeks, then thr	` '	
		2 doses of medication, it		times weekly for a period of four	, ,	
		due to non-therapeutic blood		weeks then one (1) time weekly		
		nd hospitalization was also		period of four (4) weeks or until 1		
		doses. He stated it took a		compliance is achieved and mail		
		num blood level back and it /s to occur. He noted		Findings will be documented on	uie	
	_	done on the importance of		appropriate audit tool.  The Administrator will review the		
		e medication and to call the		completed audits on a weekly ba		
	Shourning arey nad th	o meandation and to builting	1	Completed addition of a weekly be		

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		345130	B. WING _			C / <b>29/2022</b>
	ROVIDER OR SUPPLIER  US HEALTH AT CONCO	RD		STREET ADDRESS, CITY, STATE, ZI 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 580	even one dose was of Resident #1 did not in him to have breakthrough rehospitalization was medication, which was seizure. He stated it the therapeutic/optimoregulate the brain and the seizure medication it was not unusual for this to occur.  The Medical Director on 7/27/22 at 1:37 Pl Brivaracetam doses Resident #1 for 24 horesident had seizure hospitalization on 03 following the missed have expected the on notified when the medical Director was significant harm.  An interview was dor (UM) on 07/26/22 at medication administration should have notified were not given to Resident that the notified when the medication not admin DON stated that the notified when the medication when the medication when the medication was significant harm.	don't have the medication, crucial. He noted that when eceive the medication, it led ough seizures and the also due to him missing the as also a breakthrough can take many days to get the bulk between the seizures when ons were stopped. He added that it to take 5 days or more for a was interviewed via phone of the was informed the activity and resident required (19/22 and 03/24/22) doses. He stated he would be dication was not available. The stated he did not believe it that occurred.  The with the Unit Manager 11:27 AM regarding ation. She stated the nurses the Physician if medications	F 5	ensure compliance. The Director of Nursing, and/or designee will brin to the monthly QAPI med with the interdisciplinary. The IDT will discuss the changes/continuation of monthly QAPI meetings compliance.  Date of Compliance: 7/2	ng results of audits eting for review team (IDT). need for this plan during to achieve 100%	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	' '	TE SURVEY MPLETED
		345130	B. WING _		0.	C 7/ <b>29/2022</b>
	ROVIDER OR SUPPLIER	PRD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 0	1129/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	being given to agend of the paperwork title checklist, for complate and 'F580-notification noted: -report to the medical provider medications administered as order-Notification to provior orders must be documedical record.  A phone interview where we had a medical record.  A phone interview where we had a medication. He state available, given as one should be notified if available.  The Administrator where years a medical provided Allegation of IJ remoderation of IJ remoderation. The Facility provided Allegation of IJ remoderation of IJ re	ing provided an a packet on 07/27/22 that was by nurses currently. Review ed: 'New hire education int survey 8/18/21-8/31/21' in of changes' was done. It all provider/on call medical is that are unavailable to be ered. It der and response/received imented in the resident's as conducted with the 28/22 at 9:09 AM regarding eiving his Brivaracetam ed that medication should be redered and the physician the medication was not as informed of Immediate 28/22 at 10:07 AM.  If the following Credible eval.  It ients who have suffered, or serious adverse outcome as mpliance ecceive physician ordered ions on 3/18/22 due to the gravailable from the ical Director was not notified	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED		
	345130	B. WING			C <b>07/29/2022</b>
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT COM			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		0.120/2022
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
911 transported to Room. As paramerom bed to stretch Resident #1 was readmitted to the to the hospital on did not return to to the hospital on did not return to to the hospital on did not receive an ordered during the error report will be Managers for any Physician notified - Specify the action process or system adverse outcome when the action of the Nurse Managers including agency policy for notifying notification relate anti-seizure medical administration. The ensure no staff we education. Any movill receive education the Nurse Managers The Regional Direction of the Poire educated the Direction of the Nurse Managers.	The resident was assessed and the resident to Emergency edics were transferring resident ther, he had another seizure. admitted to the hospital and facility on 3/21/22. He returned 3/24/22 for seizure activity and the facility.  will complete an audit on edication Administration Records that with physician ordered cations and identify those who noti-seizure medications as e last 7 days. A Medication e completed by the Nurse of missing documentation and the dimmediately.  On the entity will take to alter the medication of the facility of the prevent a serious of the form occurring or recurring, and will be complete will re-educate licensed nurses, staff, regarding the facility's go the Physician to include do to physician ordered cations that are unavailable for the Director of Nursing will ill work without receiving this new hires, including agency staff atton prior to the start of their will be completed by 7/28/22 by	F	580		

D WING	29/2022
345130 B. WING 07/2	29/2022
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CONCORD  STREET ADDRESS, CITY, STATE, ZIP CODE  515 LAKE CONCORD ROAD NE  CONCORD, NC 28025	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 9 clinical morning meeting process to include a review of the Medication Administration Report for residents with physician ordered anti-seizure medications to identify those who did not receive anti-seizure medications as ordered and validate documentation of notification to the physician related to ordered anti-seizure medications unavailable for administration. This education was completed on 07/28/22.  Effective 07/28/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance  Alleged Date of IJ Removal: 07/29/2022  The credible allegation of Immediate Jeopardy was validated on 07/29/22 as evidenced by onsite validation through record review, observations and staff interviews. Staff were interviewed to validate in-service education completion and education rosters were reviewed.  The Immediate Jeopardy was removed on 07/29/22.  F 584 SS=B  CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	8/15/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345130	B. WING				29/ <b>2022</b>
	ROVIDER OR SUPPLIER  US HEALTH AT CONC			51	REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE DNCORD, NC 28025	1 011	29/2022
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	possible. (i) This includes enerceive care and sephysical layout of the independence and (ii) The facility shall the protection of the or theft.  §483.10(i)(2) House services necessary and comfortable into \$483.10(i)(3) Clean in good condition;  §483.10(i)(4) Private resident room, as separate shall areas;  §483.10(i)(5) Adequal levels in all areas;  §483.10(i)(6) Comfolevels. Facilities inital 1990 must maintain 1990 must main	conal belongings to the extent suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,	F	584	No residents were found to have been affected.  All residents have the potential to be affected.  On 8/1/2022, the Environmental Service.		

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NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C	•	JITEGIZOZZ
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From pag	e 11	F 5	84		
	o7/25/22 at 1:31 PM being placed in the chall. Further observe sheets with multiple blankets with large vision wash cloths with visil.  An interview conduct with the Laundry Direblankets were used the bed from being shakets do not go or beds. She stated the for wiping up spills or residents' hands. She was checked daily for	rith the Laundry Director on revealed clean linen was entral clean linen closet 100 ation revealed 3 of 7 flat black strains of hair, 3 of 10 disible yellow stains, 3 of 10 ble brown stains, and 5 of 10 ble brown stains, and 5 of 10 ble yellow and brown stains.  The don 7/25/22 at 1:36 PM ector revealed the bath underneath residents to keep oiled. She further stated the ver the top of the residents' stained linen was only used in the floor and washing the efurther revealed the linen or cleanliness or stains. She I the stained or unclean linen, een an oversight.		Manager completed an audinen and took out of circular were not in good and clean this time, a linen order was linens taken out of circulation replaced with linens in good condition.  The Regional Director of Err Services, Administrator, and will educate environmental regarding providing linen in clean condition for resident taking out of circulation liner ripped, stained, and/or not incondition. This education will completed on or before Mos 8/15/2022. Education will conewly hired environmental sincluding agency staff, prior work.	ation linens that condition. At placed, and on were d and clean and clean are in good and use, including ins that are in good will be inday ontinue with services staff,	
	at 1:38 PM revealed visible streaked brow  An interview conduct 7/25/22 at 1:40 PM reshould have been disuse. She further reveoversight on her part over the weekend.  c. An observation wit Laundry Aid #2 on 7/clean linen was being	D-Hall linen cart on 7/25/22 2 of 2 fitted sheets with large on stains.  The definition of the laundry Director evealed the fitted sheets exarded and not available for ealed it must have been an as she worked in laundry  The Laundry Aid #1 and 126/22 at 12:35 PM revealed g place on the shelf in the eas. Further observation		The Director of Nursing, Ad Nurse Managers and/or deeducate direct care staff reg providing linen in good and condition for resident use, is out of circulation linens that stained, and/or not in good This education will be completed Monday 8/15/2022. continue with newly hired dincluding agency staff, prior work.  The Environmental Service and/or designee will complete.	signee will garding clean ncluding taking t are ripped, condition. bleted on or Education will irect care staff, r to the start of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345130	B. WING _				C <b>29/2022</b>
	ROVIDER OR SUPPLIER	RD		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	1 017	ZJIZUZZ
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLET	
F 584	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	ensure that linen provide is in good and clean cor identified areas of conce corrected immediately. 8/15/2022, the Environn Manager and/or designe audit of the clean linen resident use is in good a condition. Any identified will be corrected immed be completed five (5) tin period of four (4) weeks times weekly for a perio weeks then one (1) time period of four (4) weeks compliance is achieved Findings will be docume appropriate audit tool. The Administrator will recompleted audits on a wensure compliance.  The Environmental Servadministrator and/or designed and content of the content		eern will a	
F 760 SS=J	Residents are Free of CFR(s): 483.45(f)(2)  The facility must ensu §483.45(f)(2) Resider medication errors.	f Significant Med Errors	F	760	results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT).  The IDT will discuss the need for changes/continuation of this plan durin monthly QAPI meetings to achieve 100 compliance.		7/29/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
			7 50.25 (6	·		С	
		345130	B. WING		ا ا	7/29/2022	
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CO	•	112912022	
TWANE OF T	NOVIDEN ON GOIT EIEN			515 LAKE CONCORD ROAD NE	DE		
ACCORDI	US HEALTH AT CON	CORD					
				CONCORD, NC 28025		_	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760	Continued From r	ongo 12	F 70	0			
1 700	Continued From p	age 13	F 76	00			
	by:			D :1 1 //4   F	1.6		
		ations, record review and		Resident #1 was discharged	d from the		
		ysician and neurologist		facility on 3/24/2022.			
		cility failed to administer two		On 7/29/2022 Nurse Manag	10.00		
		onvulsant (anti-seizure) sident had two episodes of		On 7/28/2022, Nurse Manag completed an audit of curren			
		d required two hospitalizations		receiving anti-seizure medica			
		ures (03/19/22-03/21/22 and		validated that these medicat			
		2) for 1 of 3 resident reviewed		available for administration.			
		dications (Resident #1).		this audit revealed no further	•		
	g			of anti-seizure medications r			
	Immediate Jeopai	dy began on 03/18/22 when the		available for administration a	Ū		
		minister two doses of an					
		edication. Resident #1 had two		The Regional Director of Clir	nical Services		
	episodes of seizu	re activity and required		educated the Director of Nur	sing, Nurse		
	hospitalization on	03/19/22 and 03/24/22.		Managers and the Administra	ator regarding		
	Immediate Jeopai	dy was removed on 07/29/22		the clinical morning meeting	process to		
	when the facility p	rovided and implemented an		include a review of residents	receiving		
		le allegation of Immediate		anti-seizure medications to v	/alidate		
		. The facility will remain out of		documentation of administra			
		ower scope and severity level D		medications as ordered by the			
	'	ith potential for more than		Education was completed or	n 7/28/2022.		
		is not immediate jeopardy) to					
		nt practice and ensure		Licensed nurses, including a			
		ns put in place to remove the		were educated regarding the			
	immediate jeopar	dy are effective.		obtaining an ordered medica			
	Fi di ildd.			unavailable for administration	_		
	Findings included	:		contacting the pharmacy to o			
	Posidont #1 was	admitted to the facility on		medication, notification of the and documentation of such.	• •		
		gnoses that included Sialidosis		was completed by 7/28/22.			
		rder that causes impaired vision		continue with newly hired lice			
		, epilepsy (seizure disorder) and		and/or agency staff prior to t			
	myoclonus (musc			work by the Director of Nursi			
	, 55.51145 (111450			Managers, and/or designee.	•		
	A physician order	for Resident #1 indicated the		inanagoro, amayor accignos.			
		edication Brivaracetam 50		Nurse Managers and/or desi	ignee will		
		let was ordered two times a day		complete an audit of the med	-		
		re disorder) on 02/11/22.		weekly on Thursdays to valid			

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		0.	C 7/ <b>29/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	72072022	
				515 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 760	Continued From page	e 14	F 76	0 medications are available for			
	Record (MAR) revea receive the two dose medication not being			administration and needs identifice corrected. Findings will be docume on the appropriate audit tool.  During regularly scheduled clinical meetings on Monday - Friday, Nu	nented al		
	On 07/27/22, the Director of Nursing obtained the Pharmacy delivery slips that indicated the Medication Brivaracetam was ordered from pharmacy on 03/17/22 and delivered late on 3/18/22 for Resident #1. A nurse had dated and signed for the medication, but no time was noted in the date field on the form.  Record review of the MAR for the Brivaracetam			Managers will review Medication Administration Records (MARs) for residents on anti-seizure medicate ensure that anti-seizure medicate available since the day of the preaudit and that anti-seizure medicate have been administered as order physician. Beginning on 7/29/202 will be completed five (5) times w	ions to ons were vious ations ed by the 22, audits		
	medication on 03/28/ to give the medicatio did not administer the #1.	22 indicated Nurse #2 failed n at 8:00 AM and Nurse #1 e 8:00 PM dose to Resident		a period of four (4) weeks, then the times weekly for a period of four (weeks then one (1) time weekly for period of four (4) weeks or until 1 compliance is achieved and main	nree (3) (4) or a 00% tained.		
	Review of the Medication Administration Record (MAR) for Resident #1 for the 03/18/22 8:00 AM Brivaracetam dose noted '9-other', and Nurse #2 documented 'waiting on pharmacy delivery.'  A phone interview was conducted on 07/27/22 at 4:24 PM with Nurse #2 regarding the 03/18/22 8:00 AM Brivaracetam dose not being administered. She did not recall the resident or the missing medication details for Resident #1.			Findings will be documented on the appropriate audit tool.  The Administrator will review the completed audits on a weekly base ensure compliance.	sis to		
				The Director of Nursing, Administ and/or designee will bring results to the monthly QAPI meeting for with the interdisciplinary team (ID The IDT will discuss the need for changes/continuation of this plan	of audits review T).		
	03/18/22 8:00 PM Br Resident #1, Nurse # PM on 03/18/22. It n pharmacy, resident v	MAR revealed for the ivaracetam dose for the had documented at 10:41 toted: "9-other, in route from titals all within normal limits."		monthly QAPI meetings to achiev compliance.  Date of Compliance: 7/29/2022	•		
	12:08 PM with Nurse						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING		C 07/29/2022	
	ROVIDER OR SUPPLIER	DRD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	1 0112012022	
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 760	03/18/22 at 8:00 PM "the medication was with pharmacy."  Record review indiction had a seizure lasting Medical Services (Eadministered two dosedative Midazolam Resident #1 was hoo Review of the MAR received his medicatupon return from the PM-03/23/22 8:00 PM Record review noted had another seizure called and he receive was transported to the Mark transported to the Minimum Data completed on 03/24 was cognitively intaction was discharged facility on 03/28/22.  The Director of Nurs 07/27/22 at 2:30 PM medication for Residuation for Residuation was not checked the automa machine, called the medication was on the seizure called the medication was on the complete of the seizure called the medication was on the complete of the seizure called the medication was on the complete of the seizure called the medication was on the complete of the seizure called the medication was on the complete of the seizure called the medication was on the complete of the seizure called the medication was on the complete of the seizure called the medication was on the complete of t	varacetam medication on I for Resident #1. She stated, not available, I had checked ated on 03/19/22 the resident g 35 minutes. Emergency MS) were called and sees intravenously (IV) of the enroute to the hospital. spitalized until 03/21/22. indicated Resident #1 tions as ordered twice daily hospital on 03/21/22 8:00 M.  If on 03/24/22, Resident #1 for 20 minutes. EMS was ed IV Midazolam by EMS and he hospital.  Set (MDS) Assessment //22 indicated Resident #1 ot.  Ital records indicated Resident #1 on the hospital to another with the hospital to another with the spital to another with	F 76			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 07/29/2022
	ROVIDER OR SUPPLIER  US HEALTH AT CONC	ORD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	OTTESTEDEE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 760	o7/27/22 at 12:46 F stated the medication used for his myoclood the seizures. He stated the seizures. He stated the seizures and getter Physician stated the when the medication Neurologist stated of medications it causes had breakthrough seizures and the seizures levels and the seconducted on the seizures levels and the seconducted in seizures levels and the seconducted on the 2 missing Resident #1 did not him to have breakthreehospitalization was medication, which we seizure. He stated the therapeutic/opti regulate the brain at the seizure medication it was not unusual full this to occur.  The Medical Direction of 19/27/22 at 1:37 Brivaracetam doses Resident #1 for 24 informed the reside 03/19/22 and 03/24 informed and seizure medication.	In the second of	F 76		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		345130	B. WING			C <b>07/29/2022</b>	
	ROVIDER OR SUPPLIER	ORD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	I	0112312022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 760	call physician would medication was not Director stated he d significant harm tha A follow-up call was	e would have expected the on I be notified when the available. The Medical id not believe it was	F 76	50			
	had reviewed the re #1 and the neurolog Brivaracetam was b seizures. He said h anticonvulsant Resi used for seizures. Brivaracetam was b	cords for Resident gist information and the eing used for tremors not the e thought the second dent #1 was on, was being The MAR indicated eing used for epilepsy and he stated it also could be					
	Administrator on 07 Resident #1 not rec medication. He stat available and given and the medication time to have the dos	vas conducted with the /28/22 at 9:09 AM regarding eiving his Brivaracetam ted that medication should be as ordered by the physician should have been ordered in sees available.					
	Jeopardy (IJ) on 07	/28/22 at 10:07 AM. d the following Credible					
		pients who have suffered, or a serious adverse outcome as ompliance.					
		receive physician ordered tions on 3/18/22 due to the g available from the					

. ,		IDENTIFICATION NUMBER.		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345130	B. WING			C <b>07/29/2022</b>	
	ROVIDER OR SUPPLIER	ORD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		OTTESTEDEE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 760	3/19/22 and was for The resident was as the resident to Eme were transferring rehe had another seiz admitted to the host facility on 3/21/22. 3/24/22 for seizure the facility.  Nurse Managers wi 7/28/22 of the Medi of current residents anti-seizure medication for the error report will be of Managers for any managers outcome from the action will have a managers with the action will have a manager with the	at #1 had seizure activity on und in bed having seizures. Seessed and 911 transported regency Room. As paramedics sident from bed to stretcher, zure. Resident #1 was poital and readmitted to the He returned to the hospital on activity and did not return to activity and did not return to activity and did not return to with physician ordered tions and identify those who seizure medications as ast 7 days. A Medication completed by the Nurse hissing documentation and the numediately.  The entity will take to alter the failure to prevent a serious om occurring or recurring, and be complete,  Il re-educate licensed nurses, aff regarding the process for nordered medications and	F 70	60			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C 07/29/2022
	ROVIDER OR SUPPLIER  US HEALTH AT CONCO	RD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		0112312022
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 760	Continued From pag		F 7	60		
	educated the Director Managers and the Addinical morning mee review of the Medical residents with physic medications to identificanti-seizure medication of no related to ordered and unavailable for admit Managers will complemedication carts dail medications are available identified will I was completed on 7/	dministrator regarding the ting process to include a tion Administration Report for sian ordered anti-seizure fy those who did not receive ons as ordered and validate tification to the physician ati-seizure medications instration. The Nurse ete an audit of the y to validate seizure lable for administration and one corrected. This education 128/22.				
		e implementation of this removal for this alleged emoval: 07/29/2022				
	Date of IJ removal 0	7/29/22				
	was validated on 07/ validation through re and staff interviews.	on of Immediate Jeopardy 29/22 as evidenced by onsite cord review, observations Staff were interviewed to ducation completion and are reviewed.				
F 812 SS=F	07/29/22.	ardy was removed on store/Prepare/Serve-Sanitary (2)	F 8	12		8/15/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
		345130	B. WING _		_	C <b>07/29/2022</b>
	ROVIDER OR SUPPLIER  US HEALTH AT CONCO	RD		01720/2022		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 812	Continued From page	e 20	F 8	12		
	§483.60(i) Food safe The facility must -	ty requirements.				
	state or local authorit (i) This may include f from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observation record review, the fact hygiene for 1 of 3 die monitor refrigerators cold foods at least 41 pimento cheese sand sandwich), and store pans) and a cutting b practice had the pote residents. The facility The findings included	red satisfactory by federal, ies. red satisfactory by federal, ies. red sold items obtained directly a subject to applicable State ulations. res not prohibit or prevent reduce grown in facility ompliance with applicable d-handling practices. res not preclude residents is not procured by the facility.  I prepare, distribute and reduce with professional revice safety. This not met as evidenced residenced residenced for sea staff interviews and collity failed to perform hand retary staff (Dietary Aide #1), remperatures for 1 of 1, store potentially hazardous degrees Fahrenheit (milk, dwiches and a bologna pans (muffin pans, sheet reduced to a census was 80 residents.		affected.  All residents residir the potential to be a On 7/27/2022, the Manager disposed potentially hazardo cleaned the bottom being used as well stored within the dr	Food Services of items stored at us temperatures and drawer of the oven as the items being rawer.	
	was observed to ope	I2 PM, Dietary Aide (DA) #1 n the kitchen door with her the kitchen, walked to the		On 8/1/2022, the R Food Services edu Services Manager	cated the Food	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NITIMBED:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			C <b>7/29/2022</b>	
NAME OF PR	ROVIDER OR SUPPLIER	_		STREET ADDRESS, CITY, STATE, ZIP COI	•		
				515 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONC	ORD		CONCORD, NC 28025			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 812	Continued From pa	ge 21	F 8	12			
	of gloves, removed assisted on the tray visibly soiled. DA # hygiene prior to dor tray line.  An interview with D 12:13 PM. DA #1 st the kitchen earlier t while she was in the hands. DA #1 state to wash her hands kitchen, she stated	e in progress, picked up a box 2 gloves, donned gloves and vine. The box of gloves was 1 did not perform hand nning gloves and assisting with  A #1 occurred on 7/25/22 at tated in interview that she left o go to the bathroom and e bathroom, she washed her d she was aware and trained upon each entry to the "I knew to do that." She stated ice that the box of gloves was		hygiene, monitoring of refrige temperatures, storing of pote hazardous cold foods, and stolean.  The Food Services Manager cooks and dietary aides regal hygiene, monitoring of refrige temperatures, storing of pote hazardous cold foods, and stolean. Education will be comon/before Monday 8/15/2022 will continue with newly hired services staff, including agent to the start of work.	entially toring items  will educate urding hand erator entially toring items appleted L. Education		
	7/25/22 at 1:22 PM perform hand hygie kitchen, and she exhands prior to assist The Administrator sthat he expected all hands upon entry to occurred on 7/25/22 the surveyor. A then the reach-in refriger of temperature mornitoring at the time revealed the following were stored 53.8 degrees F:  An 8-ounce cartor	ter (DM) stated in interview on that staff were trained to the each time they entered the expected all staff to wash their sting on the tray line.  Stated on 7/28/22 at 11:30 AM I dietary staff to wash their to the kitchen.  Of the reach-in refrigerator 2 at 12:35 PM by Cook #1 and remometer was not observed in rator and there was no record nitoring. Temperature the of the observation, ing potentially hazardous foods agrees Fahrenheit (F) to 55		The Food Services Manager designee will complete an au hand hygiene in the kitchen, staff is performing hand hygie policy. Any identified areas of be corrected immediately, ar member re-educated.  Audits will be completed five weekly for a period of four (4 three (3) times weekly for a period of four (4) weeks or uncompliance is achieved and Findings will be documented appropriate audit tool.  The Food Services Manager designee will complete an aurefrigerator temperature in the refrigerator to ensure that pot hazardous food is stored at a temperatures and record find policy. Any identified areas of	dit of the ensuring that ene per f concern will d the staff  (5) times ) weeks, then period of four weekly for a ntil 100% maintained. on the and/or dit of the e reach in tentially appropriate lings per		

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345130	B. WING		0.7	C 7/ <b>29/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		12912022	
TO UNE OF TH	TO VIDER OIL OUT TELER			515 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CON	CORD		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 812	Continued From p	page 22	F 8	12			
	·	pimento cheese and 1		be corrected immediately and	l affected		
	bologna), 55 degr			items will be immediately disc			
	bologila), oo acgi	0001		Audits will be completed five (			
	Cook #1 was inter	viewed on 7/25/22 at 12:36 PM		weekly for a period of four (4)	` '		
		e just looked in the reach-in		three (3) times weekly for a pe			
		ould not locate a thermometer.		(4) weeks then one (1) time w			
		ated that when she worked on		period of four (4) weeks or un			
		ked the reach-in refrigerator		compliance is achieved and n			
temperature and there was a thermometer there then, but that she had not checked the reach-in refrigerator temperature since 7/20/22, and when			Findings will be documented	on the			
			appropriate audit tool.				
				The Food Services Manager			
		he could not locate a		designee will complete an aud			
		. The temperature she observed		stored to ensure that items ar			
		ated was less than 41 degrees		clean. Any identified areas of	f concern will		
	F.			be corrected immediately.	(F) time		
	An intervious with	DA #1 occurred on 7/25/22 at		Audits will be completed five (			
		ealed that when she worked the		weekly for a period of four (4) three (3) times weekly for a period of four (4)			
		d not check the reach-in		(4) weeks then one (1) time w			
		rature and she could not recall		period of four (4) weeks or un			
		thermometer in the reach-in		compliance is achieved and n			
		she worked last week.		Findings will be documented			
				appropriate audit tool.			
	An interview with	DA #2 occurred on 7/25/22 at		The Administrator will review	the		
	12:38 PM and rev	ealed she remembered that she		completed audits on a weekly	basis to		
	checked the reach	n-in refrigerator temperature		ensure compliance.			
	one day last week	x, but she did not recall which		The Food Services Manager,			
	day or what the te	mperature was when she		Administrator and/or designed	e will bring		
		tated she had not checked the		results of audits to the monthl	ly QAPI		
	reach-in refrigerat	or temperature since last week.		meeting for review with the			
		U DM 7/05/00 / 40 /0 71		interdisciplinary team (IDT).			
		the DM on 7/25/22 at 12:40 PM		The IDT will discuss the need			
		ry department was currently in		changes/continuation of this p	•		
		en and had been since 7/8/22.		monthly QAPI meetings to ac	meve 100%		
		nce the dietary department		compliance.			
		orary kitchen on 7/8/22, she had ystem for monitoring the					
		reach-in refrigerator with a					
		emperature log for dietary staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345130	B. WING _		0.	C <b>07/29/2022</b>	
	ROVIDER OR SUPPLIER	RD	,	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		1120/2022	
(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 CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 812	stated she would get and post a log for die refrigeration temperate. An interview with the 11:30 AM revealed dithermometer in the refallen and got lodged stated that he expect refrigeration temperate foods 41 degrees Foods 41 d	a thermometer immediately tary staff to record tures.  Administrator on 7/28/22 at etary staff later located a each-in refrigerator that had behind a container. He ed dietary staff to monitor tures and maintain cold r below.	F8	12			
F 838 SS=F		-(3)	F 8	38		8/12/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED  C 07/29/2022		
345130			B. WING _				
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CONCORD				STREET ADDRESS, CITY, STATE, ZIP COE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 838	resources are necess competently during be and emergencies. The update that assessmeleast annually. The facupdate this assessment facility plans for, any substantial modification assessment. The facupdates or include:  §483.70(e)(1) The facincluding, but not limit (i) Both the number of the resident capacity; (ii) The care required considering the types physical and cognitive and other pertinent fact that population; (iii) The staff competer provide the level and resident population; (iv) The physical enviservices, and other pertinent fact are necessary to (v) Any ethnic, culturally affect facility, including, but food and nutrition ser §483.70(e)(2) The fact but not limited to, (i) All buildings and/o and vehicles; (ii) Equipment (medicine)	ent to determine what sary to care for its residents oth day-to-day operations e facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a on to any part of this ility assessment must cility's resident population, ted to, fresidents and the facility's by the resident population of diseases, conditions, e disabilities, overall acuity, acts that are present within encies that are necessary to types of care needed for the ronment, equipment, hysical plant considerations care for this population; and al, or religious factors that the care provided by the not limited to, activities and	F8	38			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345130			B. WING		C 07/29/2022		
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CONCORD				STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETION		
F 838	(iv) All personnel, incemployees and those contract), and volunt education and/or trainelated to resident ca (v) Contracts, memo or other agreements services or equipmenormal operations and (vi) Health informatic such as systems for patient records and eximple information with other systems for patient records and eximple information with other systems for patient records and eximple information with other systems for patient records and eximple information with other systems for patient records and eximple information with other systems for patient records and eximple information with other systems for patient records and record revision for the facility failed to revising facility assessment records and the former systems included:  The facility assessment reviewed. The former the current administr Nursing (DON) was the former Rehab Direct Manager was listed and Manager, and the formation in the systems in the formation in the systems	ific rehabilitation therapies; cluding managers, staff (both a who provide services under eers, as well as their ning and any competencies are; randums of understanding, with third parties to provide to the facility during both and emergencies; and an technology resources, electronically managing electronically sharing or organizations.  ity-based and isk assessment, utilizing an and its assessment, utilizing an and annually update the	F 838	No residents were found to have be affected.  All residents residing at the facility h the potential to be affected.  The Facility Assessment will be upday by the Administrator and/or Director Nursing on/before Thursday 8/11/20. The Facility Assessment will be review ith the Interdisciplinary Team (IDT) during an Ad-Hoc QAPI Meeting on 8/12/2022.  The Facility Assessment will be review ith the IDT during routinely held mod QAPI Meetings and necessary chan will be made at that time. Findings a necessary changes will be recorded	ave ated of 22. ewed Friday  ewed onthly ges and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345130	B. WING			07/:	29/2022	
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CONCORD				51	TREET ADDRESS, CITY, STATE, ZIP CODE  15 LAKE CONCORD ROAD NE  ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 838	Further review of the the information regard residents did not mate population. The CMS provides the resident residents based on the Data Set assessment reviewed. The CMS received Hospice care assessment documer Hospice care. The CM residents required os assessment documer ostomy care. The CM residents required be facility assessment documented 2 reside and the facility report received dialysis care documented 33 resid the facility assessmen required injections.  An interview with the 7/27/2022 at 10:53 Al Administrator had left and she took some do DON reported she had Administrator and recassessment, and the emailed the copy of the had been updated on reported she remembed Administrator with up assessment but did no located.	facility assessment revealed ding the special needs of ch the current resident 672 report (a report that census and conditions of the results of the Minimum tas) dated 7/25/2022 was 672 documented 4 residents and the facility of facility of facility of facility of facility of facility of the facility of the facility assessment that facility assessment that facility assessment that facility of facility o	F	888	monthly QAPI Meeting minutes.  The Facility Assessment will be review with the IDT during routinely held mont QAPI Meetings and necessary change will be made at that time. Findings and necessary changes will be recorded in monthly QAPI Meeting minutes.  Review and updating of the Facility Assessment will take place one (1) time each month for a period of four (4) months, then every other month for a period of four (4) months, then quarterl until 100% compliance is achieved and maintained.  The Administrator and/or designee will facilitate review of the Facility Assessment during QAPI Meetings for discussion withe interdisciplinary team (IDT).  The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100 compliance.	hly s I the  y nent ith		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CONCORD				STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	OTTESTEDEE	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 867 SS=F	the updated facility as unable to find it. The facility assessment shand at least annually administrative person the current resident preported he would up QAPI/QAA Improvem CFR(s): 483.75(g)(2)(2)(2)(3)(4)(2)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	ched for the electronic file of isessment, but he had been Administrator reported the nould be updated as needed to reflect the current nel as well as the needs of opulation. The Administrator date the facility assessment. ent Activities (iii) seessment and assurance.  Cality assessment and must:  Cament appropriate plans of iffied quality deficiencies;  Caris not met as evidenced ews. observation and staff ews, the facility's Quality mance Improvement ed to maintain implemented for interventions the face in February 2022. This ciencies which were 4/2022 during the and on the current in survey on 07/29/2022. es were a failure to notify of a failure to prepare and ince with professional rice safety (F-812). The efacility during the two cord demonstrated a pattern by to sustain an effective	F 8		g, rs of ne ng to ant to 122. red DT as	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	0.0.00	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		112912022		
TO UNE OF TH	TO VIDER OR OUT FILER			515 LAKE CONCORD ROAD NE	-			
ACCORDI	US HEALTH AT CONCO	RD						
				CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 867	Continued From page	e 28	F 86	67				
	Improvement Prograr	n.		7/28/22 of the Medication Adm	ninistration			
				Records of current residents re				
	The findings included	d:		anti-seizure medications and v	•			
				these medications have been				
	This tag is cross refer	red to:		administered during the last 7	days. A			
				Medication error report was be	e completed			
	1.a. F-580 Based on	observation, record review		by the Nurse Managers for an	y missing			
		nysician and neurologist		documentation and the Physic				
		ailed to notify a Resident's		immediately. Initial audit of re-				
		loses of an anti-convulsant		ordered anti-seizure medication				
	, ,	tion were not available to		no irregularities and no medica				
		22. This resulted in two		reports were required as a res	ult of this			
		ctivity and hospitalization d 03/24/22-03/28/22 for 1 of		audit.				
		or medication management.		The Regional Director of Clinic	cal Sanjicas			
	i residerit reviewed it	or medication management.		educated the Director of Nursi				
	1.b. During the facility's recertification and complaint investigation of 02/14/2022 F-580 wa			Managers and the Administrat				
				the clinical morning meeting p				
		ify a Resident's Physician		include a review of residents r				
		ood pressure medications		anti-seizure medications to va	-			
		administration on 07/21/21		documentation of administration	on of			
	and 07/22/21; and wh	nen the blood pressure		medications as ordered by the	physician.			
	reading was out of no			Education was completed on 7				
	residents reviewed fo	r medication management.						
				Licensed nurses, including ag	ency staff			
		y's complaint investigation of		were educated regarding the p				
		s cited for failure to notify		obtaining an ordered medication				
	•	ssessment changes for 1 of		unavailable for administration,				
	3 residents reviewed	for pressure ulcers.		contacting the pharmacy to ob				
				medication, notification of the				
		ducted with the Director of		and documentation of such. E				
	• ,	/27/22 at 5:10 PM regarding		was completed by 7/28/22. Ed				
		an. She stated that audits their 02/14/22 recertification		continue with newly hired licer and/or agency staff prior to the				
	_	g done when the incident		work. Education will continue				
		urred on 3/18/22. Review of		hired licensed nurses and/or a	-			
		work provided by the DON		during the initial orientation pro				
		· · · · · · · · · · · · · · · · · · ·		facilitated by the Director of No				
	that she stated was given to new hires and agency nurses titled: 'new hire education			Nurse Managers, and/or design	-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345130	B. WING			C <b>07/29/2022</b>		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	12912022	
TO THE OT THE	to VIDER OR OUT FEET				5 LAKE CONCORD ROAD NE			
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	0.114145	/ OTATEMENT OF DEFINITION	ID					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 867	Continued From p	age 29	F 8	367				
	checklist'-for comp	plaint survey 8/18/21-8/31/21"						
		on on F580-notification of			On 7/27/2022, the Food Services			
	changes as noted	:			Manager disposed of items stored at			
	-report to the med	ical provider/on call medical			potentially hazardous temperatures ar	ıd		
	provider medication	ons that are unavailable to be			cleaned the bottom drawer of the over	1		
	administered as o	rdered. Notification to provider			being used as well as the items being			
	and response/rece			stored within the drawer.				
	documented in the							
	TI DOM :				On 8/1/2022, the Regional Director of			
		d her files and stated an			Food Services educated the Food			
	•	s completed for Resident #1's 22 but there was no medication			Services Manager regarding hand			
	error report compl			hygiene, monitoring of refrigerator temperatures, storing of potentially				
	identified in the au			hazardous cold foods, and storing iten	ne			
	identified in the de	idio.			clean.	10		
	An interview was	done on 07/29/22 at 3:47 PM						
	with the Unit Mana	ager (UM) regarding the QAPI			The Food Services Manager will educ	ate		
		ent Process Improvement)			cooks and dietary aides regarding har			
	meetings. The UN	M stated she attended QAPI			hygiene, monitoring of refrigerator			
	meetings when sh			temperatures, storing of potentially				
	several times. Sh			hazardous cold foods, and storing iten	าร			
	occurred about no			clean. Education will be completed				
	needed when med			on/before Monday 8/15/2022. Educat	on			
	stated it has been			will continue with newly hired food	•			
	·	arter of 2022 and did not recall			services staff, including agency staff,	orior		
	_	ed. The UM was asked if she cerns with notification of the			to the start of work. Education will be	200		
		ng medications not being			completed with newly hired food service staff, including agency staff, prior to the			
		ng doses and she said no.			start of work by the Food Services	<b>C</b>		
	available of IIII33ii	ig doses and she said no.			Manager and/or designee.			
	The Director of No	ırsing (DON) was interviewed			aagor arra, or abolgitoo.			
		9/22 at 5:16PM regarding the			The Food Services Manager and/or			
		ssurance Process Improvement			designee will complete an audit of the			
		r medications. She stated that			hand hygiene in the kitchen, ensuring	that		
		PI meetings, F580 medication			staff is performing hand hygiene per			
	notification to the	Provider and medication errors			policy. Any identified areas of concern			
		g discussed. She was asked			be corrected immediately, and the sta	ff		
		ngoing issues and the DON said			member re-educated.			
	she thought it was agency nurses. She noted they							

NAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT CONCORD  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CONCORD, NC 28025)    CX4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CONCORD, NC 28025)    F 867				A. BOILDI	_	<del></del>			
ACCORDIUS HEALTH AT CONCORD    SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG			345130	B. WING			_		
CONCORD, NC 28025   CONCORD, NC 28025   CONCORD, NC 28025	NAME OF PI	ROVIDER OR SUPPLIER	1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CONCORD, NC 28025					5′	15 LAKE CONCORD ROAD NE			
F 867 Continued From page 30 try and book the same nurses for 8-12 weeks when they can, but often this was not possible. She said there needed to be more ongoing education with the agency nurses as they came and left frequently. The DON was asked if the agency nurse orientation was adequate, and she said there were things that they could add such as competencies. She noted they expected the agency nurses to be competent but that had shifted in the last couple months, and they need to do an in-house full nurse orientation and have consistent staff. She noted medication ordering needed to be included as well. She noted per the policy that was provided to her on 07/28/22 they are to reorder with 6 doses left. She added she was not familiar with the policy and would be educating staff.  An interview was conducted with the Administrator on 07/29/22 at 5:30 PM. He said that had been at the facility since 07/01/22. He stated he had not been to a QAPI meeting but had reviewed the QAPI information from May  F 867  The Food Services Manager and/or designee will complete an audit of the refrigerator to ensure that potentially hazardous food is stored at appropriate lemperatures and record findings per policy. Any identified areas of concern will be corrected immediately discarded.  The Food Services Manager and/or designee will complete an audit of the refrigerator to ensure that potentially hazardous food is stored at appropriate lemperatures and record findings per policy. Any identified areas of concern will be corrected immediately discarded.  The Food Services Manager and/or designee will complete an audit of the refrigerator to ensure that potentially hazardous food is stored at appropriate lemperatures and record findings per policy. Any identified areas of concern will be corrected immediately  The Food Services Manager and/or designee will complete an audit of the refrigerator to ensure that potentially hazardous food is stored at appropriate lemperatures and record findings per policy. Any identified areas of co	ACCORDI	IUS HEALTH AT CONCO	KD		С	ONCORD, NC 28025			
try and book the same nurses for 8-12 weeks when they can, but often this was not possible. She said there needed to be more ongoing education with the agency nurses as they came and left frequently. The DON was asked if the agency nurse orientation was adequate, and she said there were things that they could add such as competencies. She noted they expected the agency nurses to be competent but that had shifted in the last couple months, and they need to do an in-house full nurse orientation and have consistent staff. She noted medication ordering needed to be included as well. She noted per the policy that was provided to her on 07/28/22 they are to reorder with 6 doses left. She added she was not familiar with the policy and would be educating staff.  An interview was conducted with the Administrator on 07/29/22 at 5:30 PM. He said that had been at the facility since 07/01/22. He stated he had not been to a QAPI meeting but had reviewed the QAPI information from May  The Food Services Manager and/or designee will complete an audit of the refrigerator to ensure that potentially nerifyerator to ensure that potentially hazardous food is stored at appropriate temperature in the reach in refrigerator to ensure that potentially hazardous food is stored at appropriate temperatures and record findings per policy. Any identified areas of concern will be corrected immediately and affected items will be immediately discarded.  The Food Services Manager and/or designee will complete an audit of items stored to ensure that potentially hazardous food is stored at appropriate temperature in the reach in refrigerator to ensure that potentially hazardous food is stored at appropriate temperatures and record findings per policy. Any identified areas of concern will be corrected immediately and affected items will be corrected immedia	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
2022. He said in the May 2022 meeting, the recertification survey information from 02/14/22 was reviewed. The QAPI committee had discussed the F580 tag and were reviewing the audits. The Administrator said he was unable to determine the root cause of medication reordering issues without participating in the QAPI meeting. He stated anyone that was considered agency staff were to receive a packet of information.  2022. He said in the May 2022 meeting, the recertification from 02/14/22 was reviewed. The QAPI committee had discussed the F580 tag and were reviewing the meetings on Monday – Friday, Nurse Managers will review Medication Administration Records (MARs) for residents on anti-seizure medications to ensure that anti-seizure medications were available since the day of the previous audit and that anti-seizure medications have been administered as ordered by the physician and that the appropriate measures were taking if medications were unable to be administered as ordered.	F 867	try and book the sam when they can, but of She said there needed education with the agand left frequently. The agency nurse oriental said there were thing as competencies. She agency nurses to be shifted in the last count to do an in-house full consistent staff. She needed to be include policy that was provide are to reorder with 6 was not familiar with educating staff.  An interview was con Administrator on 07/2 that had been at the stated he had not been had reviewed the QA 2022. He said in the recertification survey was reviewed. The Codiscussed the F580 that audits. The Administration determine the root careordering issues with QAPI meeting. He stated agency stof information.  2.a. F-812 Based on interviews and recordering contains the recertification.	the nurses for 8-12 weeks fiten this was not possible. The dot be more ongoing gency nurses as they came the DON was asked if the tition was adequate, and she is that they could add such the noted they expected the competent but that had tiple months, and they need in nurse orientation and have in noted medication ordering did as well. She noted per the ded to her on 07/28/22 they doses left. She added she the policy and would be  adducted with the 29/22 at 5:30 PM. He said facility since 07/01/22. He ten to a QAPI meeting but the information from May May 2022 meeting, the information from 02/14/22 QAPI committee had ag and were reviewing the trator said he was unable to ause of medication thout participating in the tated anyone that was taff were to receive a packet	F	367	The Food Services Manager and/or designee will complete an audit of the refrigerator temperature in the reach in refrigerator to ensure that potentially hazardous food is stored at appropriate temperatures and record findings per policy. Any identified areas of concern be corrected immediately and affected items will be immediately discarded.  The Food Services Manager and/or designee will complete an audit of item stored to ensure that items are stored clean. Any identified areas of concern be corrected immediately.  Nurse Managers and/or designee will complete an audit of the medication ca weekly on Thursdays for a period of 12 weeks to validate seizure medications available for administration and needs identified will be corrected. Findings we be documented on the appropriate auditool.  During regularly scheduled clinical meetings on Monday – Friday, Nurse Managers will review Medication Administration Records (MARs) for residents on anti-seizure medications to ensure that anti-seizure medications wavailable since the day of the previous audit and that anti-seizure medications have been administered as ordered by physician and that the appropriate measures were taking if medications was a sure to the sure taking if medications was a sure taking taking taken and taken and taken and taken and taken	will  rts are rill dit		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		345130	B. WING			1	29/2022
NAME OF P	ROVIDER OR SUPPLIER	•	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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ACCONDI	03 HEALITTAT CONCO	ND .		С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From pages store potentially haza degrees Fahrenheit (sandwiches and a bopans (muffin pans, shoard clean. This def potential to affect food 2.b. During the facility complaint investigation cited for failure to 1) to food with an effective store cold/frozen food and date of opening. diced ham, that was running water with a frahrenheit (F). The faham, sliced turkey, Ficheese and chicken to date of opening and occurred in 2 of 3 colpotential to affect food An interview was con Administrator on 07/2 that had been at the fistated he had not been had reviewed the QA 2022. He said in the recertification survey was reviewed. The Acouldn't speculate who can a book and the stated with the second of the first populate with the stated he had not been had reviewed. The Acouldn't speculate who can be supported to the first populate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed. The Acouldn't speculate with the stated he had not been had reviewed.	e 31  ardous cold foods at least 41 milk, pimento cheese logna sandwich), and store neet pans) and a cutting icient practice had the d served to residents  y's recertification and on of 2/14/2022 F-812 was thaw a potentially hazardous food safety system, and 2) ds sealed and with a label The facility thawed frozen not submerged, under temperature of 93.4 degrees acility stored hot dogs, sliced rench fries, pancakes, sliced rench fries, pancakes, sliced rench fries without a label and open to air. This failure d storage units and had the d served to residents.  ducted with the 29/22 at 4:30 PM. He said facility since 07/01/22. He en to a QAPI meeting but PI information from May May 2022 meeting, the information from 02/14/22 administrator noted he by the issues continued		867	Managers and/or designee five (5) tim weekly for a period of four (4) weeks, three (3) times weekly for a period of four (4) weeks then one (1) time weekly for period of four (4) weeks or until 100% compliance is achieved and maintaine Findings will be documented on the appropriate audit tool.  Audits will be completed by the Food Services Manager and/or designee five (5) times weekly for a period of four (4) weeks, then three (3) times weekly for period of four (4) weeks then one (1) times weekly for a period of four (4) weeks of until 100% compliance is achieved and maintained. Findings will be document on the appropriate audit tool.  The Administrator will review the completed audits on a weekly basis to ensure compliance.  The Food Services Manager, Administrator and/or designee and Nu Managers and/or designee will bring results of audits to the monthly QAPI meeting for review with the interdisciplinary team (IDT).  The IDT will discuss the need for	es hen bur a d. e ) a me r t ted	
	because he had not permeeting.	oarticipated in a QAPI			changes/continuation of this plan durin monthly QAPI meetings to achieve 100 compliance.  The IDT will hold monthly QAPI Meetin on the pre-determined date.	)%	

AND DIAM OF CODDECTION		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		==		С			
	<b>345130</b> B. W					07/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
ACCORDI	US HEALTH AT CONCOR	RD		515 LAKE CONCORD ROAD NE			
				CONCORD, NC 28025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  PREFIX  (EACH CORRECTIVE ACTION SHOULD B  TAG  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)			SHOULD BE		(X5) COMPLETION DATE	
F 867	Continued From page	32	F8	Each member of the IDT will comonthly QAPI Meeting prepared discuss information pertinent to department.  The QAPI Coordinator and/or will maintain the monthly QAPI Minutes.  The QAPI Coordinator and/or will provide monthly QAPI meeting minutes to the Administrator at of Nursing within 3 business of QAPI Meeting being held for reserview the QAPI Meeting minutimplement new Performance Improvement Plans (PIPs) with appropriate member of the IDT indicated.  The IDT will discuss the need changes/continuation of this plan monthly QAPI meetings to ach compliance.  Completion Date: 8/15/2022	ed to o their designee I Meeting designee eting and Direct ays of the eview.  I gnee will utes and the the T as	e or e	