	-	ID HUMAN SERVICES				M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	<u>O. 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		345179	B. WING		02	C 2/08/2023
NAME OF PF	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	survey was conducter survey team returned validate the credible a Therefore, the exit da	t ID # TEQX11.	F 000			
	suvey was conducted 01/26/23. The survey on 02/08/23 to validat IJ removal. Therefore to 02/08/23. The follo investigated: NC0019 NC00192848, NC001 NC00194403, NC001	91499, NC00193540, 94035, NC00194395, 94471 and NC00197114. ons were investigated and				
	Immediate Jeopardy					
	(K) CFR 483.60 at tag 80 (K)	2 at a scope and severity 5 at a scope and severity 5 at a scope and severity				
	Immediate Jeopardy removed on 02/07/23	began on 01/22/23 and was				
F 584 SS=D		ble/Homelike Environment (7)	F 584	•		3/10/23
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE
	cally Signed	SOLI LIEN NEL NEGENTATIVE S SIGNATUR	<i>۱</i> ــ	IIILE		03/02/2023

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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 584	but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, thomelike environmen- use his or her persona- possible. (i) This includes ensure receive care and serve physical layout of the independence and do (ii) The facility shall ex- the protection of the r or theft. §483.10(i)(2) Houseke services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private of resident room, as spec §483.10(i)(5) Adequa- levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and	onment. what to a safe, clean, elike environment, including iving treatment and ig safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident uses not pose a safety risk. exercise reasonable care for esident's property from loss eeping and maintenance maintain a sanitary, orderly, ior; ed and bath linens that are	F	584			

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/07/2023 DRM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		ATE SURVEY DMPLETED
		345179	B. WING				C 02/08/2023
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDU	US HEALTH AT MOORE			75	52 E CENTER AVENUE		
ACCORDI	US HEALIN AT MOORE	SVILLE		М	IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	Continued From page	e 2	F	584			
	by: Based on observatio	is not met as evidenced			The damaged dry wall on 100 Hall a		
	damaged dry wall on affected 5 of 12 occu Room #107, Room #	failed to repair exposed 1 of 7 units (100 hall) and pied rooms (Room #103, 108, Room #109, and Room o failed to label personal care			the occupied rooms #103, #107, #10 #109, and #111 will be repaired by the maintenance department staff by 3/09/2023.		
	(400 hall) and affecte	ed bathrooms on 1 of 7 units d 3 of 6 shared bathrooms ooms #401/403, and Rooms			The personal care items in the share bathrooms on 400 hall and the affect shared bathrooms in rooms #400/ 40 #401/403, and #405/407 were replac and labeled and stored in the resider	ted)2, ced	
	The findings included	:			room on 2/01/23 by the licensed nurs		
	01/23/23 at 12:10 PM had an area approxin foot long where a boa been placed to protect	f Room #103 was made on 1. The wall behind the bed nately 5 inches wide by 5 ard (bumper board) had ct the wall from the bed. The issing exposing the dry wall			All current residents have the potent affected. An audit was completed o 2/02/23 by the licensed nurse to ens personal items are labeled and store the residents' room.	n ure	
	underneath that was bumper board was fo	damaged from the bed. The und in the bathroom with ardware that was used to			An audit will be completed by 3/9/20 the maintenance department to ensu facility damaged dry wall in the halls in resident rooms have been repaired	ire and	
	01/24/23 at 9:01 AM. an area approximatel long where a board (I placed to protect the bumper board was m underneath that was	om #103 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The issing exposing the dry wall damaged from the bed. The			The maintenance department staff we educated by the administrator by 3/9/2023 related to ensuring that fact dry walls to include walls in the hall a resident rooms are being repaired if damaged. The nursing staff will be educated by	ility and in	
	exposed wood and has secure it to the wall.	und in the bathroom with ardware that was used to om #103 was made on			3/9/2023 related to ensuring persona items are labeled and stored in the residents' room and not in shared bathrooms by the Director of Nursing (DON)/ designee.		

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345179	B. WING		02	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		o. // . =		752 E CENTER AVENUE		
ACCORD	US HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115		
(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 584	01/25/23 at 9:41 AM. an area approximate long where a board (placed to protect the bumper board was m underneath that was bumper board was for exposed wood and h secure it to the wall. An observation of Ro 01/26/23 at 10:38 AM had an area approxim foot long where a board been placed to protect bumper board was m underneath that was bumper board was for exposed wood and h secure it to the wall. b. An observation of 01/23/23 at 12:11 PM had an area approxim foot long where a board been placed to protect bumper board was m underneath that was been placed to protect bumper board was m underneath that was An observation of Ro 01/25/23 at 9:44 AM. an area approximate long where a board (placed to protect the bumper board was m underneath that was An observation of Ro	e 3 The wall behind the bed had ly 5 inches wide by 5 foot bumper board) had been wall from the bed. The bissing exposing the dry wall damaged from the bed. The bund in the bathroom with ardware that was used to bom #103 was made on M. The wall behind the bed mately 5 inches wide by 5 ard (bumper board) had ct the wall from the bed. The bissing exposing the dry wall damaged from the bed. The bund in the bathroom with ardware that was used to Room #107 was made on M. The wall behind the bed mately 5 inches wide by 5 ard (bumper board) had ct the wall from the bed. The bund in the bathroom with ardware that was used to Room #107 was made on M. The wall behind the bed. The bissing exposing the dry wall damaged from the bed.	F 58	 Maintenance staff and nursing include licensed nurses, certified assistances, certified medicati and agency nursing staff will neallowed to work until the education. The Maintenance Director will audits of the facility dry walls to walls in resident rooms and in weekly for 4 weeks and month months to ensure that damage continue to be repaired as required. The Director of Nursing/ design complete audits of 10 rooms with weeks and monthly for 2 month ensure personal items continue labeled and not stored in share bathrooms. The Administrator will submit the to the Quality Assurance Perforement (QAPI) committee meeting for 3 months for review the facility's continued compliant. 	ed nursing on aides ot be tition is be required complete o include the halls ly for 2 d dry walls uired. nee will eekly for 4 ns to e to be ed me findings rmance e monthly w to ensure	

Facility ID: 922988

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED C
		345179	B. WING			02	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	foot long where a boar been placed to protect bumper board was m underneath that was of c. An observation of F 01/23/23 at 12:15 PM had an area approxim foot long where a boar been placed to protect bumper board was ha half off the wall expose that was damaged fro An observation of Rou 01/24/23 at 9:02 AM. an area approximatel long where a board (k placed to protect the bumper board was ha half off the wall expose that was damaged fro An observation of Rou 01/25/23 at 9:45 AM. an area approximatel long where a board (k placed to protect the bumper board was ha half off the wall expose that was damaged fro An observation of Rou 01/25/23 at 9:45 AM. an area approximatel long where a board (k placed to protect the bumper board was ha half off the wall expose that was damaged fro An observation of Rou 01/26/23 at 10:40 AM had an area approxim foot long where a board been placed to protect	hately 5 inches wide by 5 and (bumper board) had at the wall from the bed. The issing exposing the dry wall damaged from the bed. Room #108 was made on 1. The wall behind the bed hately 5 inches wide by 5 and (bumper board) had at the wall from the bed. The anging half on the wall and sing the dry wall underneath om the bed. The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The anging half on the wall and sing the dry wall underneath on the bed. The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The anging half on the wall and sing the dry wall underneath om the bed.	F	584			

Facility ID: 922988

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	MENT OF HEALTH AN					FORM): 03/07/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345179	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28	3115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	half off the wall expose that was damaged from d. An observation of F 01/23/23 at 12:15 PM had an area approxim foot long where a boar been placed to protect bumper board was hat half off the wall expose that was damaged from An observation of Rom 01/24/23 at 9:03 AM. an area approximately long where a board (k placed to protect the bumper board was hat half off the wall expose that was damaged from An observation of Rom 01/25/23 at 9:46 AM. an area approximately long where a board (k placed to protect the bumper board was hat half off the wall expose that was damaged from An observation of Rom 01/25/23 at 9:46 AM. an area approximately long where a board (k placed to protect the bumper board was hat half off the wall expose that was damaged from An observation of Rom 01/26/23 at 10:44 AM had an area approxim foot long where a board been placed to protect bumper board was hat half off the wall exposed that was damaged from An observation of Rom 01/26/23 at 10:44 AM	ing the dry wall underneath m the bed. Room #109 was made on . The wall behind the bed hately 5 inches wide by 5 rd (bumper board) had t the wall from the bed. The anging half on the wall and ing the dry wall underneath m the bed. om #109 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The anging half on the wall and ing the dry wall underneath m the bed. om #109 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The anging half on the wall and ing the dry wall underneath m the bed. om #109 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The anging half on the wall and ing the dry wall underneath m the bed.	F 58	4			

Facility ID: 922988

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345179	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	01/23/23 at 12:17 PM had an area approxim foot long where a boa been placed to protect bumper board was m underneath that was An observation of Ro 01/24/23 at 9:05 AM. an area approximatel long where a board (k placed to protect the bumper board was m underneath that was An observation of Ro 01/25/23 at 9:47 AM. an area approximatel long where a board (k placed to protect the bumper board was m underneath that was An observation of Ro 01/26/23 at 10:46 AM had an area approxim foot long where a board been placed to protect bumper board was m underneath that was An interview was con Assistant (MA) on 01, walked the 100 hall a Room #107, Room # #111. He stated that h bumper boards were	e 6 Room #111 was made on I. The wall behind the bed nately 5 inches wide by 5 and (bumper board) had at the wall from the bed. The issing exposing the dry wall damaged from the bed. om #111 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The issing exposing the dry wall damaged from the bed. om #111 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The issing exposing the dry wall damaged from the bed. om #111 was made on The wall behind the bed had y 5 inches wide by 5 foot bumper board) had been wall from the bed. The issing exposing the dry wall damaged from the bed. om #111 was made on I. The wall behind the bed hately 5 inches wide by 5 ard (bumper board) had at the wall from the bed. The issing exposing the dry wall damaged from the bed. The issing exposing the dry wall damaged from the bed. The issing exposing the dry wall damaged from the bed. ducted with the Maintenance (26/23 at 10:55 AM. The MA nd observed Room #103, 108, Room #109, and Room ne was unaware that the missing or hanging half off at the facility did not use the	F	584			

Facility ID: 922988

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_		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345179	B. WING				08/2023
NAME OF PROVIDER OR S	UPPLIER		1	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDIUS HEALTH	AT MOORE	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
PREFIX (EAG	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
bumper bo were remo room at a which root that when remodelin depended they were currently t was current staff would aware of a at times th added tha throw the made. The Room #10 be in the b hurt on the going to th confirmed that were rooms tha were not li The Assist interviewe that if the be repaire the mainte Additional attention v the mainte issue was The Direct on 01/26/2 been at th	odeling and time and the m was on the a room car g and upda on when it with other is hey had on hely being ro- they had on hely being ro- they had on hely being ro- they had on hely being ro- they had on hey had on hey had on hey had on hey had on hey had on hey had on the once ther the once ther the had vis ke that. The had vis ke that. The had vis ke that. They would dist nance dep to of Nursi a at 1:22 F e facility for	e 7 hore. The MA stated that they updating the facility one here was no schedule as to he list or when. He stated me open, they would begin ting the room, but it just came open and how busy repairs. He added that e room on the 100 hall that emodeled. Generally, the maintenance department at needed to be repaired and Il out a repair ticket. He repair was made they would since the repair had been ved the bumper board from n and stated that should not ecause a resident could get wood and indicated he was ard away. The MA again aware of the bumper board not in place because the sited on his daily rounds or of Nursing (ADON) was (23 at 12:02 PM and stated d something that needed to uld fill out a form and give it artment or put it in their box. epairs were brought to our scuss the issue and have artment repair what ever the end (DON) was interviewed PM who stated she had only r a few weeks. She stated pected to observe rooms and	F	584			

Facility ID: 922988

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 584	3:23 PM. The Administ only been at the facili identified a lot of thing to be repaired. He sta	y needed repairs and ating them with the	F	584			
	rooms 400 and 402 o revealed a brown hain hair spray product sitt toiletry items were un On 01/24/23 at 10:09 observation was mad rooms 400 and 402 a items were in the sam An observation was c (NA) #1 of the shared and 402 on 01/26/23 black comb remained brief was hanging off also a soiled washclo the trash can. The NA the bathroom and exp personal items should	AM a subsequent e of the shared bathroom of nd the unlabeled personal ne position. onducted with Nurse Aide bathroom of rooms 400 at 10:50 AM. The unlabeled on the sink and a soiled the trash can. There was th lying in the floor beside A removed the items from blained that all residents' d be stored in their rooms names to prevent from esidents.					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/07/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING		_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	should be labeled with bags and kept in their indicated their person stored in the shared b b. An observation of t rooms 401 and 403 o revealed a gray bed p and 2 open bottles of sitting on the sink. All unlabeled. On 01/24/23 at 9:56 A observation was mad rooms 401 and 403 a items remained in the On 01/26/23 at 10:50 made with NA #1 of th rooms 401 and 403. T remained stored in the of skin and hair clean There was also an un on the sink. The NA m bathroom and explain personal items should and labeled with their being used on other m On 01/26/23 at 1:50 F conducted with the Di explained that the ress should be labeled with bags and kept in their	rector of Nursing who idents' personal items in their names and put in bedside tables. She al items should not be pathrooms. he shared bathroom of n 01/23/23 at 11:10 AM pan stored in the handrail skin and hair cleanser personal items were AM a subsequent e of the shared bathroom of nd the unlabeled personal e same position. AM an observation was he shared bathroom of The unlabeled bed pan e rail and the 2 open bottles ser remained on the sink. labeled black comb sitting emoved the items from the ted that all residents' d be stored in their rooms names to prevent from esidents. PM an interview was rector of Nursing who idents' personal items in their names and put in bedside tables. She al items should not be	F 58	4			

Facility ID: 922988

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345179	B. WING				08/2023
NAME OF PF	OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584 F 641 SS=D	c. An observation of t rooms 405 and 407 o revealed 2 gray wash the paper towel rack, open bottle of skin an sink and 2 urinals sitti commode. All the per On 01/24/23 at 10:12 observation was mad rooms 405 and 407 a items remained in the On 01/26/23 at 10:45 made of the shared b 407 with NA #1. The to white toothbrush, bottl and one urinal was in previous observations personal items from to that all residents' pers in their rooms and lab prevent from being us On 01/26/23 at 1:50 F conducted with the Di explained that the res should be labeled witt bags and kept in their indicated their person stored in the shared to Accuracy of Assessm CFR(s): 483.20(g)	he shared bathroom of n 01/23/23 at 12:09 PM basins stored on the top of a white toothbrush and an d hair cleanser sitting on the ing on the back of the sonal items were unlabeled. AM a subsequent e of the shared bathroom of nd the unlabeled personal e same position. AM an observation was athroom of rooms 405 and unlabeled wash basins, de of skin and hair cleanser the same position as s. The NA removed the he bathroom and explained sonal items should be stored beled with their names to sed on other residents. PM an interview was rector of Nursing who idents' personal items in their names and put in bedside tables. She al items should not be bathrooms. ents		584			3/10/23
	resident's status. This REQUIREMENT	is not met as evidenced					

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
						С
		345179	B. WING		0	2/08/2023
NAME OF P	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	US HEALTH AT MOORE	S)/II E		752 E CENTER AVENUE		
ACCORD	US HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From page	e 11	F 64	11		
	by:					
	Based on record rev	iew and staff interview the		Resident #43 and Residen	t #22 Minimum	
		ately code the Minimum		Data Set (MDS) coding was	-	
	. ,	e areas of antipsychotic		the MDS Coordinator on 1/2		
		velling catheters (Resident		area of antipsychotic medic		
	sampled residents.	nd Resident #51) for 3 of 6		Resident #51 MDS coding by the MDS Coordinator on area of indwelling catheter.	1/26/23 in the	
	The findings included	i:		All current residents on anti		
	1. Resident #43 was	admitted to the facility on		medications and who have		
		ses that included major		catheters have the potentia	•	
	-	dementia, psychosis, and		affected. An Audit was com		
	anxiety.			2/24/2023 by the Regional Reimbursement Consultant		
	Review of a physicial	n order dated 03/31/22 read,		residents that are prescribe		
		chotic) 0.25 milligrams (mg) a day related to psychosis.		medications and residents indwelling catheters MDS a coded.		
	Review of the compre	ehensive annual MDS dated				
	-	at Resident #43 was severely		The MDS coordinator was	educated on	
	cognitively impaired f	for daily decision making and		2/28/23 by the Regional Cli	nical	
		total assistance with		Reimbursement Consultant		
		g. The MDS indicated that		residents that are prescribe		
		ed 7 days of an antipsychotic		medications and residents	-	
		e assessment reference ent Antipsychotic Medication		catheters MDS are accurate MDS Coordinators will not		
		N0450 that asked if the		work until the education is o		
		ipsychotic medications since		New hires also will be requi		
	admission/entry or re			complete the education.		
	that no antipsychotic			The MDS Coordinator will o	complete audits	
		ided regarding the Gradual		of the facility MDS assessm		
	Dose Reduction (GD	R)or Date of last attempted,		MDS assessments continue		
		ew, Medication Follow up, or		accurately in the areas of ir		
	Medication intervention by MDS Nurse #2.	on. The MDS was completed		catheters and antipsychotic weekly for 4 weeks and mo	onthly for 2	
				months to ensure continued	d compliance.	

Facility ID: 922988

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 093 (X3) DATE SURVI	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	. ,	3	COMPLETED	
					С	
		345179	B. WING		02/08/20)23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ACCORD	IUS HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COM THE APPROPRIATE	(X5) IPLETIOI DATE
F 641	antipsychotic during t period and that the la follow up questions a entry error" on her pa The Director of Nursi on 01/26/23 at 1:03 F expected MDS Nurse that she was docume to be completed as a the required informat The Administrator wa 3:31 PM who stated t been at the facility he concerns with the cor had time to address t expected the MDS to the required informat 2. Resident #22 was 02/27/18 with diagno depressive disorder w A review of Resident notes dated 11/21/22 mg had been receive [Quetiapine] as its us current standards of p dose reduction) atten impair this individual ⁴	MDS Nurse #2 esident #43 had received an the assessment reference ick of information at the t N0450 was just a "data art. ng (DON) was interviewed PM. The DON stated that she e #2 to investigate the things enting and expected the MDS ccurately as possible with all ion. as interviewed on 01/26/23 at that in the few weeks he had e had identified some mpletion of MDS but had not them yet. He stated he be coded accurately with all ion. admitted to the facility on ses that included major with behavioral disturbances. #22's Psychiatric progress revealed [Quetiapine] 25 d twice daily. "Continue e is in accordance with practice and a GDR (gradual npt at this time is likely to	F 64	1 The MDS Coordinator will findings to the Quality Ass Performance Improvemen committee monthly meetin for review to ensure the fa continued compliance.	urance it (QAPI) ng for 3 months	
	underlying medical co disorder". A review of the Dece	mber 2022 Medication d indicated Resident #22				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/07/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING _					C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, Z	IP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BI		(X5) COMPLETION DATE
F 641	medication used to he milligrams (mg) by mo The quarterly Minimu assessment dated 12 #22 received an antip during the assessmer GDR had not been do clinically contraindicat completed by MDS N On 01/25/23 3:50 PM with the Minimum Dat confirmed Resident # GDR had not been do clinically contraindicat explained that she did progress notes and on Director's progress notes aware that the GDR h being clinically contra stated she should hav An interview was com Nursing (DON) on 01, indicated that her exp Nurse review the entit completed the MDS at questions appropriate The Administrator wat 3:31 PM who explaine had been at the facilit concerns with the cor	elp reduce psychosis) 25 both twice a day. m Data Set (MDS) /21/22 revealed Resident psychotic medication daily nt period. The MDS noted a boumented by a physician as ted. The MDS was urse #1. an interview was conducted ta Set Nurse #1 who 22's 12/21/22 MDS noted a boumented by a physician as ted. The MDS Nurse d not look at the Psychiatric nly looked at the Medical bees and therefore, was not had been documented as indicated. The MDS Nurse ve included the information. ducted with the Director of /26/23 1:50 PM. The DON pectation was that the MDS re medical record when she assessments and answer the ely. s interviewed on 01/26/23 ed that in the few weeks he ty he has identified some npletion of MDS's but had ss them yet. He stated his ne MDS to be coded	F	541				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	E SURVEY	
		345179	B. WING	NG _			C	
	ROVIDER OR SUPPLIER	545175			STREET ADDRESS, CITY, STATE, ZIP CODE	02	/08/2023	
NAME OF P	ROVIDER OR SUPPLIER				752 E CENTER AVENUE			
ACCORD	US HEALTH AT MOORES	SVILLE			MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 641	 #2. Resident #51 was 12/30/22 with diagnos pressure wound, muscommunication deficit A review of Resident Data Set (MDS) asserevealed resident to be Resident #51 was not catheter. A review of Resident revealed no order for catheter. A review of Resident revealed no mention admitted with an indw An observation of Resident revealed no mention admitted with an indw An observation of Resident Rindwelling urinary catter. During an interview w 01/23/23 at 12:19 PM never had a catheter. During an interview w 10:53 AM, she report Resident #51. She state heard that Resident # During an interview w Nursing on 01/26/23 at 32 at 32	 a admitted to the facility on sees that included stage IV scle weakness, and cognitive the scle weakness, and cognitive the scle weakness, and cognitive the second to the facility of the resident of the resident of the resident being velling urinary catheter. a sident #51 on 01/23/23 at esident #51 did not have an heter. b the weaknest familiar with admitted to the facility. b the was familiar with ated she had never seen or the second resident being velling urinary catheter. b the the Assistant Director of at 12:15 PM, he reported he ident #51, and he did not had utilized an indwelling e admission. 	F	541				

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		ND HUMAN SERVICES				RM APPROVE 10. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			TE SURVEY MPLETED	
	345179		B. WING		C 02/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER	·	STR	EET ADDRESS, CITY, STATE, ZIP CO	DE		
ACCORDI	US HEALTH AT MOORE	SVILLE		E CENTER AVENUE ORESVILLE, NC 28115			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE	
F 641 F 656 SS=D	complete the Minimul indicted Resident #57 urinary catheter. She noted that way becau aide on 01/01/23 indi bladder incontinence the use of an indwelli she would have seen would have verified it physician orders, spe she would have made Resident #51. She re though the MDS asse During an interview w on 01/26/23 at 3:15 F nurse that completed have verified the doc medical record was a the use of an indwelli reported she expected correct and accurate. Develop/Implement O CFR(s): 483.21(b)(1)	she reported she did not m Data Set assessment that 1 had utilized an indwelling reported it was most likely use data entry by a nurse cated Resident #51's could not be rated due to ing catheter. She reported if that documentation, she was correct by reviewing eaking to the hall nurses and e a visual observation of ported it appeared to her as essment was inaccurate. With the Director of Nursing PM, she reported the MDS the assessment should umentation in Resident #51's accurate before she noted ing urinary catheter. She ed MDS assessments to be comprehensive Care Plan (3)	F 641			3/10/23	
	resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The cor describe the following	ames to meet a resident's I mental and psychosocial fied in the comprehensive nprehensive care plan must					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		0.45470					C
		345179	B. WING			02/	08/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	or maintain the reside physical, mental, and required under §483.2 (ii) Any services that y under §483.24, §483. provided due to the re- under §483.10, include treatment under §483 (iii) Any specialized ser- rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's good desired outcomes. (B) The resident's pre- future discharge. Fac- whether the resident's community was assess local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set forth section. §483.21(b)(3) The se by the facility, as outli care plan, must- (iii) Be culturally-comp This REQUIREMENT by: Based on observatio and staff interview's tr implement a compre- resident that wandered	ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 3.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and efference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate use. n the comprehensive care in accordance with the n in paragraph (c) of this rvices provided or arranged ined by the comprehensive petent and trauma-informed. ' is not met as evidenced ns, record review, resident,	F	656	Resident #43 was placed on hospice of 2/2/23 and is no longer wandering. Resident #54 comprehensive care plan was updated on 1/25/23 by the MDS coordinator to address the desired wei	1	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/07/2023 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345179	B. WING				C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
400000				7	52 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORES	SVILLE		Μ	IOORESVILLE, NC 28115		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	17	F	656			
	weight (Resident #54			000	loss.		
	reviewed.	101 2 01 4 residents					
	The findings included				All current residents have the potential be affected. An audit will be completed		
					3/9/2023 by Regional Clinical	by	
	1. Resident #43 was a	admitted to the facility on			Reimbursement Consultant to ensure		
	01/17/20 with diagnos	-			comprehensive care plan are being		
	-				updated to include wandering residents	3	
		hensive annual Minimum			and residents that have a desired weig	ht	
	, ,	d 11/04/22 revealed that			loss.		
		verely cognitively impaired					
	-	king and had no behaviors,			The Minimum Data Set (MDS)		
	•	andering. The MDS further nt #43 used a wheelchair for			Coordinator was educated on 2/28/23 the Regional Clinical Reimbursement	у	
		one person assistance with			Consultant to ensure residents'		
	mobility on and off the	-			comprehensive care plans are being		
	5				updated to include wandering residents	6	
	Nurse Aide (NA) #9 a	nd #10 were interviewed on			and residents that have a desired weig	ht	
		Both confirmed that they			loss.		
		nere Resident #43 resided.			MDS coordinators will not be allowed to	2	
		sidents wandered on their			work until the education is completed.		
	unit, they both replied				New hires also will be required to		
	wanders all over the predirected and indicat	ted that wandering was not			complete the education.		
		nt #43. They both indicated			The MDS Coordinator will complete au	dits	
		ndered daily for quite some			of the facility comprehensive care plan		
	time.				ensure comprehensive care plans		
					continue to be updated to include		
	Review of Resident #				wandering residents and residents with		
	revealed no care plan	n for wandering.			desired weight loss weekly for 4 weeks		
	An abaaminting of D				and monthly for 2 months to ensure		
		sident #43 was made on			continued compliance.		
		Resident #43 was up in her propelling herself in/out of			The MDS Coordinator will submit the		
	other resident rooms				findings to the Quality Assurance		
					Performance Improvement (QAPI)		
	An observation of Res	sident #43 was made on			committee monthly meeting for 3 month	าร	
		Resident #43 was up in her			for review to ensure the facility's		
	wheelchair and prope	lling herself in/out of other			continued compliance.		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/07/2023 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345179	B. WING				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28	3115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	resided. An observation of Res 01/24/23 at 3:25 PM. be propelling herself of she resided. She was resident rooms and co Nurse #3 was intervie and confirmed that sh Resident #43 resided residents on her unit of Resident #43, and ad wandered on and off of redirected. MDS Nurse #1 was in 3:01 PM and confirme wandered all over the redirected. She stated wander guard (signali wore to alert staff if th place and to her know planned her wanderin confirmed that Reside basis but was not cap no one documented h stated, "if it had been certainly been care pl An observation of Res 01/25/23 at 4:34 PM. wheelchair and was p and was observed go rooms and common a	d off the unit where she sident #43 was made on Resident #43 was noted to on another unit then where observed in/out of other ommon areas. wed on 01/24/23 at 3:26 PM wandered, she replied ded that Resident #43 the unit but was easily the unit but was easily thetrviewed on 01/25/23 at ed that Resident #43 building daily but was easily d that she did not have a ng device that residents ey exited the facility) in vledge they have never care g behavior. She again ent #43 wandered on a daily tured on the MDS because her wandering behavior and on the MDS it would have anned." sident #43 was made on Resident #43 was up in her ropelling herself on the unit ing in/out of other resident treas.	F 65	56			
	interviewed on 01/26/	of Nursing (ADON) was 23 at 11:23 AM who ent #43 wandered all over					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	the building but was e stated that the staff of building where aware belong over there and back to the appropria would think her wand care planned." He sta their clinical meeting t that occurred during t plans were updated ri stated that they also d or things that needed staff and again the ca then and there. The A behavior would requir safety and should be An observation of Rei 01/26/23 at 12:12 PM was up in her wheelch herself on/off the unit common areas. The Director of Nursir on 01/26/23 at 1:03 P only been at the facili was not familiar with the The DON stated she resident wandered da planned. 2. Resident #54 wa 03/02/22. Review of the quarter dated 12/13/22 revea cognitively intact and with eating. The MDS Resident #54 weigher	easily redirected. The ADON in the other side of the that Resident #43 did not d would assist her in getting te unit. The ADON stated "I ering behavior would be ated that each morning in they discussed all events he previous day, and care ight then and there. He discussed any other issues closer observation by the are plans were updated right ADON stated the wandering re close observation for care planned. sident #43 was made on I revealed that Resident #43 hair and was propelling and in/out of rooms and the residents that wandered. would expect that if the aily that it would be care s readmitted to the facility on thy Minimum Data Set (MDS) led that Resident #54 was required set up assistance	F	656	6		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		345179	B. WING			C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				·	752 E CENTER AVENUE			
ACCORD	US HEALTH AT MOORE	SVILLE			MOORESVILLE, NC 28115			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	period. Review of a physiciar regular diet, sugar fre condiments, fruit for of vegetables and prote three meals, no bread An interview was con 01/23/23 at 2:48 PM. 01/16/23 he had an a and his surgeon advis have surgery, he nee pounds. Resident #54 Physician Assistant (I his desire to lose weil the surgery that he ne stated that he agreed recommendations of restrictions to achieve Review of Resident # revealed no care plar to lose weight, or the implemented to help The Registered Dietic	n order dated 01/18/23 read, be beverages and dessert, large portion of in. Large protein portions all d, no tea, and no dessert. ducted with Resident #54 on Resident #54 stated that on ppointment with his surgeon sed that before he could ded to lose about 50 4 stated that he met with the PA) at the facility to address ght so that he could undergo eeded to have. Resident #54 with the PA's dietary changes and e his goal of weight loss. 554's medical record in that addressed his desire nutritional interventions	F	656				
	that the PA at the faci Resident #54's desire the nursing facility the but because Residen desire to loose weigh dietary restrictions an Resident #54 achieve The RD stated she ha interventions or Resid							
	-	etween her visits the MDS						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345179	B. WING				08/2023
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE NOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 677 SS=E	needed, she added it update the care plans MDS Nurse #1 was in 2:31 PM. She stated it care plan diet or dieta only care planned ass #1 stated that each m meeting they went ov had discussed Reside weight and intervention weight loss I would hat planned that information The Assistant Director interviewed on 01/26/ stated that the PA had #54 had verbalized th and had agreed to a stand extra protein. The #54's desire to lose w implemented to help it should be documented The Director of Nursin on 01/26/23 at 1:03 P had only been at the fit stated she expected F weight and implement documented on the ca ADL Care Provided for CFR(s): 483.24(a)(2) A resid	y adjustments that were was a collaborative effort to s. Atterviewed on 01/25/23 at that she generally did not ary restrictions and generally sistive devices. MDS Nurse borning in their clinical er any new orders and if we ent #54's desire to lose ons to help him with the ave immediately care ion. r of Nursing (ADON) was 23 at 11:23 AM. The ADON d informed him that Resident at he wished to lose weight specific diet with no bread e ADON stated that Resident reight and interventions nim achieve his weight loss d on the care plan. ng (DON) was interviewed M. The DON stated that she facility for a few weeks but Resident #54's desire to lose ted interventions to be are plan. or Dependent Residents ent who is unable to carry		656			3/10/23
		iving receives the necessary jood nutrition, grooming, and jiene;					

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345179 NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZI 752 E CENTER AVENUE MOORESVILLE, NC 28115 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN (EACH OERECTIVE A CROSS-REFERENCED T DEFICIE F 677 Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #75) to 6 of 8 residents reviewed for activities of daily living. Resident #74, #184, and showered on 2/1/2023 b Nursing Assistant. Resident #75 was provid 2/1/2023 by the Certified N 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease. All current residents hav affected. An audit was ca 2/1/2023 by the Director to ensure residents are	DF CORRECTION (X5) CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZI ACCORDIUS HEALTH AT MOORESVILLE 752 E CENTER AVENUE MOORESVILLE, NC 28115 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN. (EACH ORRECTIVE A CROSS-REFERENCED T DEFICIE F 677 Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident #75) to 6 0 8 residents reviewed for activities of daily living. Resident #75 was provid 2/1/2023 by the Certified Assistant. The findings include: 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease. All current residents hav affected. An audit was ca 2/1/2023 by the Director	DF CORRECTION (X5) CTION SHOULD BE O THE APPROPRIATE (X5) COMPLETION DATE
752 E CENTER AVENUE MOORESVILLE, NC 28115 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN. (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE F 677 Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident #75) to 6 of 8 residents reviewed for activities of daily living. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease. Resident #74 was admitted to the facility on 01/2023 by the Director	DF CORRECTION (X5) CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
ACCORDIUS HEALTH AT MOORESVILLE MOORESVILLE, NC 28115 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN. (EACH OERRECTIVE A CROSS-REFERENCED T DEFICIE F 677 Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident #75) to 6 of 8 residents reviewed for activities of daily living. Resident #73 was provid 2/1/2023. Resident #75 declined to 2/1/2023 by the Certified Assistant. The findings include: 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease. All current residents have affected. An audit was co 2/1/2023 by the Director	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
Image: Non-Structure Model is a structure Model is	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
PRÉFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEF 677Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.Residents with shower for activities of daily living.The findings include: 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.Resilent for activities of bar and the facility on 01/05/23 by the Director	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident #75) to 6 of 8 residents reviewed for activities of daily living.Resident #74, #184, and showered on 2/1/2023 by Nursing Assistant.The findings include: 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.Residence activities of ally living.Resident #75 declined to 2/1/2023 by the Certified Assistant.All current residents may affected. An audit was co 2/1/2023 by the DirectorAll current residents have affected. An audit was co 2/1/2023 by the Director	
This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident #75) to 6 of 8 residents reviewed for activities of daily living.Resident #74, #184, and showered on 2/1/2023 by Nursing Assistant.The findings include: 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.Residence activities of a audit was co 2/1/2023 by the Director	1
by:Resident #74, #184, and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.Resident #183 was disch 1/30/2023.The findings include:The findings include:Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	
Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.Resident #183 was disch 1/30/2023. Resident #53 was provid 2/1/2023 by the Certified Assistant.The findings include:Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	
dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.Nursing Assistant. Resident #183 was disch 1/30/2023. Resident #53 was provid 2/1/2023 by the Certified Assistant.The findings include:Resident #75 declined to 2/1/23 by the Certified N1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	1 #186 was
#183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.Resident #183 was disch 1/30/2023. Resident #53 was provid 2/1/2023 by the Certified Assistant.The findings include:Resident #75 declined to 2/1/23 by the Certified N1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	y the Certified
care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.1/30/2023. Resident #53 was provid 2/1/2023 by the Certified Assistant.The findings include:Resident #75 declined to 2/1/23 by the Certified N1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	
(Resident#75) to 6 of 8 residents reviewed for activities of daily living.Resident #53 was provid 2/1/2023 by the Certified Assistant.The findings include:Resident #75 declined to 2/1/23 by the Certified N1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	larged on
activities of daily living.2/1/2023 by the Certified Assistant.The findings include:Resident #75 declined to 2/1/23 by the Certified N1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	ed nail care on
The findings include:Assistant.The findings include:Resident #75 declined to 2/1/23 by the Certified N1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease.All current residents have affected. An audit was co 2/1/2023 by the Director	
2/1/23 by the Certified N 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease. 2/1/2023 by the Director	-
01/05/23 with diagnoses that include chronic obstructive pulmonary disease. All current residents have affected. An audit was constructive pulmonary disease. 2/1/2023 by the Director 2/1/2023 by the Director	
obstructive pulmonary disease.affected. An audit was constructive pulmonary disease.2/1/2023 by the Director	
2/1/2023 by the Director	
	-
assessment dated 01/12/23 revealed Resident showered, and nail care	-
#74 was cognitively intact and was totally required.	
dependent on staff for bathing.	
The nursing staff to inclu	
Resident #74's care plan dated 01/17/23 revealed nurses, certified nursing	
she had a self-care deficit performance related tocertified medication aideweakness. The goal that she would improve innursing staff will be educ	
her current level of functioning would be attained related to ensuring reside	-
by providing extensive assistance of one staff for showers, shaved and na	-
bathing. by the DON/ designee.	
The nursing staff to inclu	
On 01/23/23 at 11:24 AM an interview and nurses, certified nursing observation were made of Resident #74 of her certified medication aide	
observation were made of Resident #74 of her certified medication aide hair appearing dry and stiff and pulled back in a nursing staff will not be a	
ponytail. The Resident was dressed in clean until the education is cor	
clothing and there were no odors noted. The hires also will be required	-
Resident explained that her hair had not been education.	
washed nor had she had a shower since she was	
admitted to the facility. She stated she was being The Director of Nursing/	
wiped off but every time she had asked the "girls" complete audits of 10 res	-
(nurse aides) for a shower, she was told the hall 4 weeks and monthly for had recently been opened to residents and the ensure residents continu	sidents weekly for

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED
		345179	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115	
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO HE APPROPRIATE DATE
F 677	Continued From page		F 67		
		the hall had not been made continued to express that		showered, and nail care pro	ovided.
	she was used to takir home.	ng two showers a week at		The Director of Nursing will findings to the Quality Assu Performance Improvement	rance (QAPI)
On 01/24/23 at 2:59 PM an observation made of the shower schedule book for 100/200/300 and 400 halls. There was n schedule made up for 400 hall.	schedule book for halls. There was no shower		committee monthly meeting for review to ensure the fac continued compliance.		
	January 2023 reviewe	#74's bathing record for ed documentation of being /17/23 and 01/20/23 by			
	#2 on 01/26/23 at 10: that she did not work have made a mistake	ducted with Nurse Aide (NA) 56 AM. The NA explained on 01/17/23 and she must in her documentation on e has never given any 400 hall.			
	Nurse Aide #3 she re frequently and confirm hall had been schedu the hall had recently of shower schedule had The NA continued to was responsible for d	PM during an interview with ported she worked 400 hall ned that no resident on 400 iled for a shower because opened to residents and the I not been developed yet. explain that the Scheduler leveloping the 400-hall I it had not been done yet.			
	During an interview w 01/24/23 at 3:50 PM frequently worked 400 showered a resident (01/24/23). The NA co hall had recently open	vith Nurse Aide #4 on the NA explained that he			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/07/2023 MAPPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345179	B. WING			_		C 08/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE 100RESVILLE, NC 28 [.]	115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page	24	F	677					
	the Scheduler was reashower schedule for thad just recently oper had not been develop frequently worked 400 showered any resider. On 01/25/23 at 1:50 F conducted with Nurses she frequently worked showered one resider that hall from another never showered a new because the shower a made up yet. An interview was conditioned to a shower that the resider received a shower un continued to explained that admitted to 400 hall of aware that the resider received a shower un continued to explain the showers. An interview was conditioned to a shower shower of the shower of the resider received a shower un continued to explain the resider received a shower un continued to explain the shower of the showers. An interview was conditioned that she was not responsible for the resider received a shower un continued to explain the shower of the shower show	 Aide #6 who explained that sponsible for making up the he halls and since 400 hall hed, the shower schedule bed yet. The NA stated she 0 hall and she had not ht on that hall. PM an interview was e Aide #5 who explained that d 400 hall and had only ht that was transferred to hall. She stated she had w resident from the hall schedule had not been ducted with the Assistant DON) on 01/24/23 at 1:52 at the first resident was in 01/05/23 and he was not hts on that hall had not 							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	, í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345179	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	 During an interview w (DON) on 01/26/23 at she had only been in early January and sta the Scheduler who wa developing the showe not done that and was residents on the hall f their admission. The f acceptable. Resident #183 was diagnoses that include The admission Minim assessment dated 01 #183 was cognitively extensive assistance The MDS also indicat have a behavior of rej Resident #183's care revealed he had a sel related to weakness. improve in his current be attained by providi one staff for bathing. During an interview a #183 on 01/23/23 at 2 was disheveled and g explained that he had couple of showers a w given or offered a sho The Resident had no given bed baths but w showers, he was told 	with the Director of Nursing t 1:50 PM she explained that the DON position since ited she was not aware that as responsible for er schedule for 400 hall had is not aware that the had not had a shower since DON stated it was not a admitted on 01/17/23 with ed anemia. um Data Set (MDS) /23/23 revealed Resident intact and required of one person for bathing. red the Resident did not jection of care. plan dated 01/17/23 If-care deficit performance The goal that he would t level of functioning would ng extensive assistance of and observation of Resident 2:31 PM the Resident greasy. The Resident	F	677			

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	-	ID HUMAN SERVICES				FORI	M APPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE	E SURVEY PLETED	
		345179	B. WING				C / 08/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT MOORES	SVILL F			752 E CENTER AVENUE		
ACCOUND	oo neaenn ar moorret				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 677	Continued From page	26	F	67 ⁻	7		
	made of the shower s	halls. There was no shower					
	January 2023 reviewe	#183's bathing record for ed documentation of being /20/23 by Nurse Aide (NA)					
	on 01/26/23 at 10:56 she must have made documentation on 01/	ducted with Nurse Aide #2 AM. The NA explained that a mistake in her /20/23 because she has ent a shower on 400 hall.					
	Nurse Aide (NA) #3 s hall frequently and co 400 hall had been sch because the hall had and the shower scheo yet. The NA continued Scheduler was respon	recently opened to residents dule had not been developed					
	frequently worked 400 showered a resident of (01/24/23). The NA co hall had recently oper shower schedule had On 01/24/23 at 3:55 F conducted with Nurse	the NA explained that he D hall and had never on that hall until that day ontinued to explain that the ned to residents and the not been made up yet.					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/07/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMF	SURVEY PLETED
		345179	B. WING			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
	US HEALTH AT MOORES				752 E CENTER AVENUE			
ACCORDI	US REALTH AT MOORES	SVILLE			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	had just recently oper had not been develop frequently worked 400 showered any resider On 01/25/23 at 1:50 F conducted with Nurse she frequently worked showered one resider that hall from another never showered a new because the shower s made up yet. An interview was com Director of Nursing (A PM who explained that admitted to 400 hall of aware that the resider received a shower un continued to explain to responsible for formul schedule but failed to unacceptable for the new showers. An interview was com- on 01/25/23 at 9:50 A that she was not resp shower schedule for r the only thing she was showers was to colled turn them into the form	he halls and since 400 hall hed, the shower schedule ed yet. The NA stated she 0 hall and she had not at on that hall. PM an interview was 4 Aide #5 who explained that 4 400 hall and had only at that was transferred to hall. She stated she had w resident from the hall schedule had not been ducted with the Assistant DON) on 01/24/23 at 1:52 at the first resident was n 01/05/23 and he was not hts on that hall had not	F	677	7			
	she had only been in	-						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 03/07/2023 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345179	B. WING			02/0	08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28	8115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	the Scheduler who wa developing the showe not done that and was residents on the hall h their admission. The h acceptable. 3. Resident #184 was 01/10/23 with diagnos mellitus. The admission Minim assessment dated 01 #184 was cognitively extensive assistance The MDS also indicat behaviors of rejection Resident #184's care revealed he had a sel related to weakness. improve in his current be attained by providi bath when a shower of On 01/23/23 at 2:26 F observation with Resi expressed he had not washed since he was hair appeared matted Resident stated when getting a shower, he w recently been opened been made up yet. Th and stated he was be like getting a complete On 01/24/23 2:59 PM	as responsible for er schedule for 400 hall had is not aware that the had not had a shower since DON stated it was not a admitted to the facility on ses that include diabetes um Data Set (MDS) /17/23 revealed Resident intact and required of one person for bathing. red the Resident had no of care. plan dated 01/22/23 if-care deficit performance The goal that he would t level of functioning would ng a full bath or sponge cannot be tolerated. PM during an interview and dent #184 the Resident t had a shower, or his hair admitted to the facility. His , dry, and disheveled. The ne asked the staff about was told the hall had and the schedule had not ne Resident had no odors ing wiped off, but it was not	F 67	7			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345179	B. WING			02	/08/2023	
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 677	up for 400 hall. A review of Resident January 2023 reviews given a shower on 01 Nurse Aide (NA) #2. An interview was com on 01/26/23 at 10:56 she did not work on 0 made a mistake in he 01/20/23 because she resident a shower on On 01/24/23 at 1:11 F Nurse Aide (NA) #3 s hall frequently and co 400 hall had been sch because the hall had and the shower sched yet. The NA continued Scheduler was respon 400-hall shower sched done yet. During an interview w 01/24/23 at 3:50 PM f frequently worked 400 showered a resident of (01/24/23). The NA co hall had recently oper shower schedule had On 01/24/23 at 3:55 F conducted with Nurse the Scheduler was re	no shower schedule made #184's bathing record for ed documentation of being /17/23 and 01/20/23 by ducted with Nurse Aide #2 AM. The NA explained that 1/17/23 and she must have r documentation on e has never given any 400-hall. PM during an interview with he reported she worked 400 nfirmed that no resident on heduled for a shower recently opened to residents dule had not been developed d to explain that the nsible for developing the dule and it had not been with Nurse Aide #4 on the NA explained that he D hall and had never on that hall until that day pontinued to explain that the ned to residents and the not been made up yet. PM an interview was e Aide #6 who explained that sponsible for making up the	F	677				
	shower schedule for t	he halls and since 400-hall ned, the shower schedule						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345179	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 677	had not been develop frequently worked 400 showered any resider On 01/25/23 at 1:50 F conducted with Nurse she frequently worked showered one resider that hall from another never showered a ner because the shower s made up yet. An interview was con Director of Nursing (A PM who explained that admitted to 400 hall of aware that the resider received a shower un continued to explain the responsible for formut schedule but failed to unacceptable for the firshowers. An interview was con on 01/25/23 at 9:50 A that she was not resp shower schedule for the showers was to colled turn them into the form During an interview was (DON) on 01/26/23 at she had only been in early January and stat the Scheduler who was	bed yet. The NA stated she 0 hall and she had not int on that hall. PM an interview was a Aide #5 who explained that d 400 hall and had only int that was transferred to thall. She stated she had w resident from the hall schedule had not been ducted with the Assistant ADON) on 01/24/23 at 1:52 at the first resident was on 01/05/23 and he was not ints on that hall had not til today. The ADON hat the Scheduler was lating the 400-hall shower do that. He stated it was residents to go without their ducted with the Scheduler M. The Scheduler explained tonsible for formulating the new admissions. She stated s responsible for as far as ct the bathing sheets and mer Director of Nursing. tith the Director of Nursing t 1:50 PM she explained that the DON position since ited she was not aware that	F	677			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
		345179	B. WING				08/2023	
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 677	their admission. The DON stated it was no 4. Resident #186 was 01/16/23 with diagnos failure. The admission Minim had not been complet The Nursing Admissio 01/16/23 revealed Re oriented and was tota activities of daily living Resident #186's care revealed he had a sel related to respiratory would improve in his of participation would be dependent of one stat During an observation Resident #186 on 01/ Resident was lying in had not had a shower 01/16/23. The Reside he was used to taking home but had yet to r had explained to him offered a shower. The stated he was given b to receive a shower.	s not aware that the had not had a shower since t acceptable. a admitted to the facility on ses that included respiratory um Data Set assessment ted. on assessment dated esident #186 was alert and illy dependent on staff for all g. plan dated 01/23/23 if-care deficit performance failure. The goal that he current level of function e attained by being totally ff for bathing. n and interview with 23/23 at 2:10 PM the bed and explained that he r since his admission on ent continued to explain that g 2-3 showers a week at eceive a shower and no one why he had not been e Resident had no odors and bed baths but would also like	F	677				
	made of the shower s 100/200/300 and 400	chedule book for halls. There was no shower						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/07/2023 APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		345179	B. WING				C 08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
				752 E CENTER AVENUE				
ACCORDI	US HEALTH AT MOORES	VILLE		MOORESVILLE, NC 28	115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page schedule made up for		F 67	7				
	January 2023 reviewe	#186's bathing record for ed documentation of being /17/23 and 01/20/23 by						
	on 01/26/23 at 10:56	e has never given any						
	Nurse Aide (NA) #3 sl hall frequently and co 400 hall had been sch because the hall had and the shower scheo yet. The NA continued Scheduler was respon	recently opened to residents dule had not been developed						
	frequently worked 400 showered a resident of (01/24/23). The NA co hall had recently oper	he NA explained that he						
	the Scheduler was res shower schedule for t had just recently oper	PM an interview was Aide #6 who explained that sponsible for making up the he halls and since 400 hall hed, the shower schedule red yet. The NA stated she						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/07/2023 MAPPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345179	B. WING			_		C 08/2023	
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•		
ACCORDI	US HEALTH AT MOORES	WILLE			752 E CENTER AVENUE MOORESVILLE, NC 28	115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page frequently worked 400 showered any resider On 01/25/23 at 1:50 F conducted with Nurse she frequently worked showered one resider that hall from another never showered a new because the shower s made up yet. An interview was com Director of Nursing (A PM who explained that admitted to 400 hall o aware that the resider received a shower un continued to explain t responsible for formul schedule but failed to unacceptable for the r showers. An interview was como on 01/25/23 at 9:50 A that she was not resp shower schedule for r the only thing she was showers was to colled turn them into the forr During an interview w (DON) on 01/26/23 at she had only been in	 a 33 D hall and she had not int on that hall. PM an interview was a Aide #5 who explained that d 400 hall and had only int that was transferred to hall. She stated she had we resident from the hall schedule had not been ducted with the Assistant (DON) on 01/24/23 at 1:52 at the first resident was in 01/05/23 and he was not ints on that hall had not til today. The ADON hat the Scheduler was lating the 400-hall shower do that. He stated it was residents to go without their ducted with the Scheduler (M. The Scheduler explained onsible for formulating the new admissions. She stated is responsible for as far as ct the bathing sheets and mer Director of Nursing. with the Director of Nursing to the total the DON position since ited she was not aware that 		677					
		er schedule for 400-hall had							

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	OMB NO. 0938-0391
AND PLAN OF CORRECTION (XT) PROVIDENCIOPPLENCEIA (XZ) MOLTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C
345179 B. WING	02/08/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	TE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE 752 E CENTER AVENUE MOORESVILLE, NC 2811	15
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	PLAN OF CORRECTION (X5) TIVE ACTION SHOULD BE COMPLETION CED TO THE APPROPRIATE DATE EFICIENCY)
F 677 Continued From page 34 F 677 residents on the hall had not had a shower since their admission. The DON stated it was not acceptable. 5. Resident #75 was admitted to the facility on 01/06/23 with diagnoses that included cerebral vascular accident. The admission Minimum Data Set (MDS) assessment dated 01/13/23 revealed Resident #75's cognition was moderately impaired and required extensive assistance of one for personal hygiene. The MDS also indicated the Resident had no behaviors of rejection of care. Review of Resident #75's Kardex (a guide to his daily care) dated 01/23/23 revealed the Resident required extensive assistance for personal hygiene. During an interview and observation of Resident #75 on 01/23/23 at 12:17 PM the Resident was lying in bed with facial hair approximately quarter inch long. The Resident every day at home. The Resident every day at home. The Resident every day at home. The Resident was lying in bed with facial hair approximately quarter linch long. The Resident was lying a shower yesterday (01/22/23) but was not shaved. He stated the "giff" told him she would shave him today (01/23/23). An interview was conducted with Nurse #2 on 01/26/23 at 9:40 AM who explained that on 01/23/23 at 9:40 AM who explained that on 01/23/23 at 9:40 AM who explained that on 01/23/23 at 9:40 AM who explained that the fact and that the shave that she could not find razors and his response was that they just did not flow was to look for the	

Facility ID: 922988

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345179	B. WING				08/2023	
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 677	razors. On 01/24/23 at 4:15 F	e 35 PM Resident #75 was lying dent still had facial hair	F	677	7			
	with Nurse #1 and Nu explained that she wa Resident #75 on 01/2 Nurse Aide #7 (who a care) informed her that to shave the Residen	AM during a conversation urse Aide (NA) #7 the Nurse as the Nurse responsible for 23/23 and 01/24/23 and assisted with Resident #75's at she could not find a razor t on those days. The Nurse d razors for Resident #75 on						
	9:02 AM she confirme Resident #75 on 01/2 explained that he req could not find a razor despite looking throug	with NA #7 on 01/26/23 at ed that she worked with 3/23 and 01/24/23 and uested to be shaved but she to shave the Resident gh two medical supply she reported it to Nurse #2.						
	with Resident #75 on Resident was lying in shaved. The Residen	ervation were conducted 01/25/23 at 12:20 PM. The bed and had not been t explained that the "girl" told have him today (01/25/23).						
	#5 on 01/25/23 at 1:5 that Resident #75 wa would let you know w continued to explain t Resident on Saturday because he did not as	ducted with Nurse Aide (NA) 0 PM. The NA explained s alert and oriented and that he needed. She that she showered the y but did not shave him sk to be shaved. The NA n shower days and when the						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/07/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345179	B. WING			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	WILLE			752 E CENTER AVENUE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	was working with the and would make sure During an observation Resident #75 on 01/2 Resident was lying in The Resident stated t shave me yesterday to An interview conducte on 01/26/23 at 9:15 A shave Resident #75 of give an explanation at there were razors available the surve located. A box of apput the supply room. An interview with the conducted on 01/26/2 explained that there we available to the staff, them. An interview conducted of Nursing (ADON) or ADON explained that shaved every day if the (they did not have to we During an interview we (DON) on 01/26/23 at explained that the rest	haved. The NA stated she Resident that day (01/25/23) the got a shave. In and interview with 16/23 at 9:00 AM the bed and still had facial hair. the "girl" said she would but never did. ed with Nurse Aide (NA) #5 M revealed she did not on 01/25/23 and could not s to why. The NA reported ailable in the supply room eyor where the razors were roximately 12 razors were in Supply Clerk (SC) was 23 at 9:45 AM. The SC were plenty of razors they just had to look for ed with the Assistant Director n 01/24/23 at 1:52 PM. The the residents should be hat was what they desired wait until their shower days). with the Director of Nursing t 1:50 PM the DON sidents should be shaved on d everyday if that was their he was familiar with	F	677				

Facility ID: 922988

If continuation sheet Page 37 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/07/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345179	B. WING					C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 677	An observation of Rei 4:00 PM revealed he had no facial hair. 6. Resident #53 was diagnoses that includ dementia. The quarterly Minimu assessment dated 12 #53 was cognitively in assistance of one per The MDS also indicat have behaviors of reju On 01/24/23 at 9:18 A observation were mad she was eating her br feeding herself and w her fingernails which approximately ¼ to ½ fingertips. Her fingern under several nails ar edges. Resident #53 like to wear her nails assistance in cutting to do it by herself. On 01/24/23 at 1:15 F made of Resident #53 remained unchanged An interview was mad on 01/24/23 at 1:19 P worked with Resident found her to be alert a continued to explain t	sident #75 on 01/26/23 at was sleeping in bed and admitted on 09/08/22 with ed diabetes mellitus and m Data Set (MDS) /06/22 revealed Resident ntact and required extensive roon for personal hygiene. ted the Resident did not ection of care. AM an interview and de of Resident #53 while reakfast. The Resident was as noted to be looking at were long, and a inches past the end of her tails had dark brown debris nd some nails had jagged explained that she did not long and she needed them because she could not PM an observation was 3's fingernails and they de with Nurse Aide (NA) #3 PM who explained that she i #53 the last 2 days and	F	677				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED IB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION) DATE SURVEY COMPLETED C
		345179	B. WING			02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677 F 688 SS=D	accompanied the sur- room and observed the be long, jagged and v underneath several of they needed to be trire explained that she just nurse with Resident # condition of her finger closer attention to the During an interview w Nursing on 01/24/23 at the residents' fingernat trimmed on their show An interview conducted Nursing (DON) on 01, the residents' fingernat cleaned on their show The DON stated the resident of the residents' fingernation services (c) (1) The factor resident who enters the range of motion unless condition demonstrated of motion is unavoidat §483.25(c)(2) A resides motion receives appro- services to increase resident and the residents' for the resident states and the resident states and the residents' find the resident states and the resident sta	veyor to Resident #53's ne Resident's fingernails to vith brown debris f her fingernails and stated nmed and cleaned. The NA st finished assisting the #53 and did not notice the rnails and she needed to pay a residents' fingernails. Vith the Assistant Director of at 1:52 PM he explained that ails should be cleaned and wer days and as needed. ed with the Director of /26/23 at 1:50 PM revealed ails should be trimmed and ver days and as needed. hurse aides should always esidents' fingernails as they d provide nail care as crease in ROM/Mobility -(3) cility must ensure that a he facility without limited not experience reduction in as the resident's clinical es that a reduction in range ble; and ent with limited range of		577		3/10/23

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CENTER	MENT OF HEALTH AN S FOR MEDICARE & I		(X2) MULTIPLE	CONSTRUCTION	(FORM	03/07/2023 APPROVED 0938-0391 URVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPLE	
		345179	B. WING			C 02/0 3	8/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE		52 E CENTER AVENUE IOORESVILLE, NC 28115	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	39	F 688				
	receives appropriate s assistance to maintain the maximum practica reduction in mobility is This REQUIREMENT by: Based on observation and staff interview's th apply a hand splint ar 1 of 3 residents review (Resident #48). The findings included Resident #48 was rea 05/31/21 with diagnos infarction, osteoarthrit Review of a care plan Resident #48 was ress of refusals of wearing included: educate ress of noncompliance and behavior is appropriat Review of a documen Transition Record dat Occupational Therapy Resident #48 to the N following program: Re wearing bilateral splin prefers to wear the sp place palm guard on I splints and may wear plan included numero #48 wearing splints an	admitted to the facility on ses that included cerebral is, and others. revised on 06/09/22 read, istive to care with a history splints. The interventions ident on possible outcomes d praise the resident when re. t titled Rehab to Restorative ed 09/21/22 indicated that		Resident #48 splint v licensed nurse on 2/ All current residents t have the potential to a was completed on 2/ Director of Nursing (D residents' splints are ordered. The nursing staff to in nurses, certified nursi certified medication a nursing staff will be en- by the DON/ designed residents' splints are ordered. The nursing staff to in nurses, certified nursi certified medication a nursing staff will not b until the education is hires also will be requ education. The Director of Nursin complete audits of resi weekly for 4 weeks an months to ensure resi	1/2023. hat wear splints affected. An audit 1/2023 by the DON) to ensure being applied as include licensed ing assistants, ide and agency ducated by 3/9/202 e related to ensurir being applied as include licensed ing assistances, ides and agency be allowed to work completed. New lired to complete the ing/ designee will sidents with splints ind monthly for 2 idents with splints	ne	

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345179	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115	
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 688	Continued From page 40		F 68	38	
	 Review of a physician order dated 09/27/22 read; Wrist, Hand, Finger, Orthosis (WHFO splint) up to six hours a day with patient preferring splints to be donned in the evening after his evening medication pass. Don in the evening and Doff in the morning. Staff to place left palm guard on left hand following doffing of bilateral WHFO. Review of a quarterly Minimum Data Set (MDS) dated 12/23/22 revealed that Resident #48 was cognitively intact for daily decision making and required extensive to total assistant with activities of daily living. The MDS further indicated that 			The Director of Nursing will findings to the Quality Assu Performance Improvement committee monthly meeting for review and will follow up ensure the facility's continu	rance (QAPI) g for 3 months o as needed to
	Resident #48 had im extremities that interf	pairments to bilateral upper ered with activities of daily are was noted during the			
	Review of a physician order dated 01/03/23 read; Wrist, Hand, Finger, Orthosis (WHFO splint) up to six hours a day with patient preferring splints to be donned in the evening after his evening medication pass. Don in the evening and Doff in the morning. Staff to place left palm guard on left hand following doffing of bilateral WHFO.				
		ation Administration Record / 2023 revealed no record of ard application.			
		ent Administration Record 2023 revealed no record of ard application.			
	with Resident #48 on Resident #48 was res	nterview were conducted 01/23/23 at 3:03 PM. sting in bed. His bilateral owards the palm of his hand.			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING _				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ACCORD	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE OORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Resident #48 stated t hand and stated I "ca open them." There we noted in place and no Resident #48's room. An observation and ir with Resident #48 on Resident #48 was res splints or palm guard stated that none of th the splints last night." asked if he refused th replied, "lord no I wisk can't get anyone to st Resident #48 further months ago therapy f they put them on for a they could not find the seen them since them An observation and ir with Resident #48 on Resident #48's bilater toward his palm and t guard in place or note again stated that no c on and was adamant application of them. An observation of Res 01/25/23 at 9:46 AM. bed; his bilateral hand towards his palm. The guard in place, and m The Therapy Director 01/25/23 at 10:03 AM	hat he could not open his nnot get anyone to help me ere no splints or palm guard one were observed in hterview were conducted 01/24/23 at 9:52 AM. sting in bed and had no in place. Resident #48 e staff offered to or applied When Resident #48 was he splints or palm guard he in they would put them on, I raighten out my fingers." explained that several itted him for splints, and about two weeks then stated em anymore and he has not b. hterview were conducted 01/24/23 at 3:30 PM. ral hands remained curled there were no splints or palm ed in his room. Resident #48 one had offered to put them that he would not refuse the sident #48 was made on Resident #48 was resting in ds and fingers were curled ere was no splint or palm one were visible in his room.	F	688			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345179	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE NOORESVILLE, NC 28115		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 688	2022 and a splitting s the staff educated on The Therapy Director did not have a formal application fell to the resident was discharg did not have any furth NA #10 was interview and confirmed that sh Resident #48 on the of was unaware of any s needed to be applied further stated that Re splints in place when Nurse #3 was intervie AM and stated that th palm guard when the Resident #48 would r applied during the day the evening shift. Nur currently did not have palm guard and Reside with therapy, so he w any splints or palm gu NA #9 was interviewe and confirmed she ro the unit where Resides she was unaware of a that needed to be app added that when she #48 did not have any to be removed. NA #11 was interview and confirmed that he	chedule was developed and the application process. explained that the facility restorative program so the NAs to do and once the ged from therapy, they really her follow up. red on 01/25/23 at 11:47 AM the routinely cared for day shift. She stated that splints or palm guard that to Resident #48. NA #10 sident #48 did not have any she arrived for duty. weed on 01/25/23 at 11:48 erapy was applying the splints came off but efuse them when they were y so they switched them to se #3 stated that they e an order for the splints or dent #48 was not working as currently not receiving uard. and on 01/25/23 at 11:54 AM utinely worked day shift on ent #48 resided. She stated any splints or palm guard olied to Resident #48 and arrived for duty Resident splints in place that needed	F	688			

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				OMB NC	APPROVED . 0938-0391
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
345179	B. WING				C 08/2023
		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		7	752 E CENTER AVENUE		
LC	MOORESVILLE, NC 28115				
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD F		(X5) COMPLETION DATE
ts or palm guard that sed to wear. He t been offering to apply because he had no idea y that needed to be d via phone on 01/25/23 d that he routinely n Resident #48. He all any splint schedule the would look on the n residents required or the NAs would apply 44 again confirmed that splints or palm guard d. <i>via</i> phone on 01/25/23 at hat she routinely cared ight shift. NA #12 stated splints, and no one has y splints at nighttime." <i>via</i> phone on 01/25/23 at hat she routinely cared ight shift. NA #13 stated splints that he wore. She had a splint, but she as still supposed to ted that she did not <i>y</i> splints to Resident #48 n the night shift. Nursing (ADON) was at 11:49 AM who stated be wearing his splints t he had heard rumors	F	688			
E ESC - tetoy address So Anis y Anise atter Partit	IDENTIFICATION NUMBER: 345179 LE ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) As or palm guard that ed to wear. He been offering to apply because he had no idea y that needed to be Via phone on 01/25/23 d that he routinely neesident #48. He all any splint schedule he would look on the residents required or the NAs would apply 4 again confirmed that splints or palm guard d. ia phone on 01/25/23 at at she routinely cared ght shift. NA #12 stated splints, and no one has y splints at nighttime." ia phone on 01/25/23 at at she routinely cared ght shift. NA #13 stated splints, but she as still supposed to ted that she did not r splints to Resident #48 in the night shift. Nursing (ADON) was t 11:49 AM who stated be wearing his splints	PROVIDER/SUPPLIER/CLIA (X2) MULE IDENTIFICATION NUMBER: A. BUILD 345179 B. WING LE ID ENT OF DEFICIENCIES ID ST BE PRECEDED BY FULL PREFI DENTIFYING INFORMATION) TAG IS or palm guard that Preceduce Is or palm guard that F is phone on 01/25/23 F ia the routinely F ia phone on 01/25/23 at F ia phone on 01/25/23 at <td>PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING 345179 B. WING</td> <td>PROVIDER/SUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING 345179 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 72 C ENTER AVENUE MOORESVILLE, NC 28115 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENT OF DEFICIENCIES TO FDEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION) PROVIDERS TAG St or palm guard that ed to wear. He been offering to apply eccause he had no idea y that needed to be F 688 I'via phone on 01/25/23 if hat he routinely resident's required or the NAs would apply 4 again confirmed that splints or palm guard d. F ia phone on 01/25/23 at at she routinely cared ght shift. NA #12 stated splints, and no one has y eplints at nighttime." Iii aphone on 01/25/23 at at she routinely cared ght shift. NA #13 stated splints, nd no one has y splints at nighttime." ia phone on 01/25/23 at at she routinely cared ght shift. NA #13 stated splints that he wore. She had a splint, but she as still supposed to ted that she did not 's plints that he did not 's plints that he ad not 's plints is plints the he had heard rumors</td> <td>PROVIDEBUSUPPLIENCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COMP 345179 B. WING (0) 732 E CENTER AVENUE WOORSSVILLE, NC 28115 (0) 732 E CENTER AVENUE WOORSSVILLE, NC 28115 ENT OF DEFICIENCIES STEE PERCEDED BY FULL PERTIFYING INFORMATION) PREX TAG PROVIDER'S PLAN OF CONSECTION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Is or palm guard that ed to wear. He been offering to apply ecause he had no idea y that needed to be F 688 via phone on 01/25/23 th that he routinely resident Frequired or the NAs would apply 4 again confirmed that splints chedule he would look on the resident srequired of the MA'12 stated phints that he wore. She had a splint, but she as still supposed to ted that she did not splints that he wore. She had a splint, but she as still supposed to ted that she did not splints that he wore. She had a splint, but she as still supposed to ted that she did not splints in that MA'13 stated phints that he wore. She had a splint, but she as still supposed to ted that she did not splints in that AfA'3 stated phints that he wore. She had a splint, but she as still supposed to ted that she did not splints in that MA'3 stated be wearing his splints.</td>	PROVIDER/SUPPLIER/CLIA (X2) MULTIPL IDENTIFICATION NUMBER: A. BUILDING 345179 B. WING	PROVIDER/SUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING 345179 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 72 C ENTER AVENUE MOORESVILLE, NC 28115 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL ENT OF DEFICIENCIES TO FDEFICIENCIES ST BE PRECEDED BY FULL ENTIFYING INFORMATION) PROVIDERS TAG St or palm guard that ed to wear. He been offering to apply eccause he had no idea y that needed to be F 688 I'via phone on 01/25/23 if hat he routinely resident's required or the NAs would apply 4 again confirmed that splints or palm guard d. F ia phone on 01/25/23 at at she routinely cared ght shift. NA #12 stated splints, and no one has y eplints at nighttime." Iii aphone on 01/25/23 at at she routinely cared ght shift. NA #13 stated splints, nd no one has y splints at nighttime." ia phone on 01/25/23 at at she routinely cared ght shift. NA #13 stated splints that he wore. She had a splint, but she as still supposed to ted that she did not 's plints that he did not 's plints that he ad not 's plints is plints the he had heard rumors	PROVIDEBUSUPPLIENCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COMP 345179 B. WING (0) 732 E CENTER AVENUE WOORSSVILLE, NC 28115 (0) 732 E CENTER AVENUE WOORSSVILLE, NC 28115 ENT OF DEFICIENCIES STEE PERCEDED BY FULL PERTIFYING INFORMATION) PREX TAG PROVIDER'S PLAN OF CONSECTION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Is or palm guard that ed to wear. He been offering to apply ecause he had no idea y that needed to be F 688 via phone on 01/25/23 th that he routinely resident Frequired or the NAs would apply 4 again confirmed that splints chedule he would look on the resident srequired of the MA'12 stated phints that he wore. She had a splint, but she as still supposed to ted that she did not splints that he wore. She had a splint, but she as still supposed to ted that she did not splints that he wore. She had a splint, but she as still supposed to ted that she did not splints in that MA'13 stated phints that he wore. She had a splint, but she as still supposed to ted that she did not splints in that AfA'3 stated phints that he wore. She had a splint, but she as still supposed to ted that she did not splints in that MA'3 stated be wearing his splints.

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/07/20 FORM APPROVE OMB NO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345179	B. WING		C 02/08/2023
NAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO	
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115	
04015	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 688	Continued From page	a 44	F 68	8	
		hould be offering them and	1.00		
		ered and then documenting			
		otance or refusal of the			
	splints and palm gua	rd.			
	The Director of Nursi	ng (DON) was interviewed			
		PM who stated that Resident			
		splints and palm guard and			
		ed as ordered and then			
F 692	documented on the N Nutrition/Hydration S		F 69	12	3/10/23
SS=D	CFR(s): 483.25(g)(1)		100	2	5/10/25
	(Includes naso-gastri both percutaneous en	nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and d on a resident's			
		ssment, the facility must			
	of nutritional status, s desirable body weigh balance, unless the r	ins acceptable parameters such as usual body weight or at range and electrolyte esident's clinical condition is is not possible or resident otherwise;			
	§483.25(g)(2) Is offer maintain proper hydr	red sufficient fluid intake to ation and health;			
	there is a nutritional provider orders a the This REQUIREMEN	red a therapeutic diet when problem and the health care rapeutic diet. Γ is not met as evidenced			
	by: Based on observation	ons, record review and		Resident #22 will be provide	ad the
	Registered Dietician			Resident #22 will be provide	ed the

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			COMPLETED	
		345179	B. WING			0	C 2/08/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				75	52 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORE	SVILLE		м	OORESVILLE, NC 28115		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 692	Continued From page	a 15		692			
1 032				092			
		ne facility failed to provide a			All current residents have the natest	al to	
		nt as recommended by the for a resident with significant			All current residents have the potenti affected. An audit will be completed		
		residents reviewed for			3/9/2023 by the Director of Nursing	J y	
	nutrition (Resident 22				(DON) to ensure residents are provid	led	
					nutritional supplements as ordered.		
	The findings included	l:			The nursing staff to include licensed		
	Resident #22 was ad	mitted to the facility on			The nursing staff to include licensed nurses, certified nursing assistants,		
		ses that included Alzheimer's			certified medication aide and agency		
	-	ht loss, and dementia.			nursing staff will be education by 3/9		
					related to ensuring residents are pro-		
	Review of a care plar	n revised on 10/22/22 read in			nutritional supplements as ordered b		
		as at risk for significant			DON/ designee.	-	
	weight loss due to a r	mechanically altered diet.					
		t #22 was that she would			The dietary staff to include agency st		
		utritional status with no			will be educated by 3/9/2023 related	to	
	0	anges through the next			ensuring nutritional supplements as		
		ions included: offer fluids			ordered are on resident meal trays.		
		upplements as ordered, <i>r</i> ide, and serve diet as			The Dietary staff to include agency d	iotory	
		stance as needed during			staff will not be allowed to work until		
	meals.				education is completed. New hires a		
					will be required to complete the educ		
	Review of a RD note	date dated 12/19/22 read in			· ·		
	part, Resident #22's	weights continue to be			The nursing staff to include licensed		
	-	all loss of 33 pounds. Pureed			nurses, certified nursing assistances		
		e portions. Intake range			certified medication aides and agenc		
		s but averages 51-75% of			nursing staff will not be allowed to we		
		itions: begin whole milk at			until the education is completed. New		
	meals three times a c	lay.			hires also will be required to complet education.	eule	
	Review of the quarter	rly Minimum Data Set (MDS)					
		led that Resident #22 had			The Director of Nursing/ designee wi		
	-	nemory problems and was			complete audits of at least 10 reside	nts	
		for daily decision making.			that require nutritional supplements		
		at Resident #22 required			weekly for 4 weeks and monthly for 2		
		with eating, weighted 127			months to ensure residents with nutr	itional	
	pounds (ips.), and ree	ceived a mechanically			supplements continue to receive the		

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		ID HUMAN SERVICES MEDICAID SERVICES			I	NTED: 03/07/2023 FORM APPROVED B NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345179	B. WING			C 02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, S	STATE, ZIP CODE	
ACCORDI	US HEALTH AT MOORE			752 E CENTER AVENUE		
ACCORDI	US REALTH AT MOURE	SVILLE		MOORESVILLE, NC 2	8115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page	e 46	F 69	12		
	altered diet. The MDS			nutritional suppler	ment as ordered.	
	last month/or a weigh months.	nt loss of 10% in the last 6		findings to the Qu Interdisciplinary (
	read in part, Residen concerning weight tree weight loss x 180 day 30 days. Eating 50-10 diet. Whole milk adde 12/20/22. Refused su receives frozen nutrit and large portions. T included: discontinue begin large potions d frozen nutritional trea				for 3 months for review n recommendations to '⊡s continued	
	was made on 01/24/2 ticket on Resident #2 receive whole milk wi	sident #22's breakfast tray 23 at 09:05 AM. The meal 2's tray indicated she was to th her meal. There was no al tray. Large portions were ate.				
	made on 01/24/23 at on Resident # 22's tra receive whole milk wi	sident #22's lunch tray was 12:15 PM. The meal ticket ay indicated she was to th her meal. There was no the meal tray. Large portions eal plate.				
	01/24/23 at 12:51 PM	lurse Aide (NA) # 6 on I she stated she feeds and she stated she had Ik on her meal trays				
		sident #22's breakfast tray 23 at 09:10 AM. The meal				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345179	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORD	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE 100RESVILLE, NC 28115		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 692	ticket on Resident # 2 to receive whole milk no whole milk noted of portions were noted of In interviews with NA at 09:13 AM, they sta large amounts of food good amount of her m further stated they alv fed Resident #22 freq ever seeing milk on h In an interview with th AM. The RD has been since June 2022 for w had added whole milk caloric intake and Res frozen nutrition cup an further stated that it w pureed meals to get t regular diet and that w weight loss when resi The RD stated as res their disease process eating adequately, the there is only so much their weight. Addition seven months they tri interventions including Resident #22 refused continue to see what with increasing Resid prevent further weigh An interview was con AM with interim Dieta stated she has been	22's tray indicated she was with her meal. There was on the meal tray. Large on the meal plate. #5 and NA #14 on 01/25/23 ted Resident #22 received d with each meal and ate a heals without difficulty. They ways worked on this unit and uently and did not recall er meal trays. he RD on 01/25/23 at 09:39 in following Resident # 22 weight loss. She stated they a with meals to increase her sident #22 also received a nd large portions. She vas difficult for residents on he same nutrition as with a was why they often see dents go on a pureed diet. idents start to decline due to , and although they may be ey start losing weight and they could do to maintain heally, she stated over the last ed many nutritional g supplements, some and some she accepted, to might have been effective ent's #22's caloric intake to	F	692			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 692	leave. She stated she that whole milk with e 22's Kardex (a system overview of each resis should be receiving w The DM could not exp not on Resident #22's An observation of Res made on 01/25/23 at on Resident #22's tra receive whole milk wi whole milk noted on the portions were noted of In an interview with the PM, the MD stated Res significant decline in m dementia in last year. really nothing else the continuing the interve whole milk three times nutritional cup twice a portions to change Res and outcome as she end-of-life phase." An interview was com Nursing on 01/26/23 (was her expectation t diet and nutrient supp by the RD. An interview was com Administrator on 01/2 stated it was his expect	e could see in the computer ach meal was on Resident # in that gives a quick and brief dent) and Resident #22 whole milk with each meal. blain why the whole milk was a meal trays as ordered. sident #22's lunch tray was 12:30 PM. The meal ticket y indicated she was to th her meal. There was no he meal tray. Large on the meal plate. The (MD) on 01/24/23 at 03:05 esident #22 has had a mental status along with her The MD stated there was ey could do besides ntions already put in place; s a day with meals, a day and large meal esident #22's weight loss was "coming towards the ducted with the Director of 01:48 PM, and she stated it hat all residents receive the olements as recommended ducted with the for the tall residents nutrient supplements as	F	692			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/08/2023		
		345179	B. WING					
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	US HEALTH AT MOORE			7!	52 E CENTER AVENUE			
ACCORDI	US HEALTH AT MOORE	SVILLE		M	IOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From page	e 49	F	695				
F 695 SS=D	Respiratory/Tracheos CFR(s): 483.25(i)	stomy Care and Suctioning	F	695			3/10/23	
	The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the compret care plan, the resider and 483.65 of this sull This REQUIREMENT by: Based on observation interview's the facility at the prescribed rate oxygen concentrator reviewed for respirator. The findings included Resident #11 was add 09/06/22 with diagnos respiratory failure and pulmonary disease. Review of a physiciar oxygen at two liters we respiratory failure. Rin concentrator filters we Review of the Medica (MAR) dated January following: Rinse or refilter weekly on Wedm	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered hts' goals and preferences, bpart. T is not met as evidenced ins, record review, and staff failed to administer oxygen e and failed to clean the filter for 1 of 3 residents bry care (Resident #11). I: mitted to the facility on ses that included acute d chronic obstructive n order dated 09/07/22 read, ia nasal cannula for nse or replace oxygen eekly and as needed. ation Administration Record 7 2022 revealed the place oxygen concentrator nesday's and as needed on indicated this was last done			Resident #1 oxygen concentrator was adjusted to the prescribed rate and the filter cleaned on 2/1/2023 by the license nurse. All current residents have the potential be affected. An audit was completed or 2/1/2023 by the Director of Nursing (DC to ensure residents' oxygen concentrate filters are cleaned and oxygen is being administrated at the prescribed rate. The licensed nurses will be educated b 3/9/2023 by the DON/ designee related ensuring residents' oxygen concentrato filters are clean and the oxygen is being administrated at the prescribed rate. The licensed nurses to include agency licensed nurses will not be allowed to work until the education is completed. New hires also will be required to complete the education.	ed to DN) ors y to prs		
	on on norzo by mulse	, πυ.			The Director of Nursing/ designee will			

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE	CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,				MPLETED
							С
		345179	B. WING				02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORE	SVILLE			2 E CENTER AVENUE OORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 695	Continued From page	e 50	F 6	95			
	Review of the quarter dated 01/06/23 revea moderately cognitively making and required activities of daily livin that Resident #11 use shortness of breath d reference period. An observation of Re 01/23/23 at 12:01 PM in bed in no acute dis have an oxygen cam connected to a conce bed and was set to d The filter on the back completely white with An observation of Re 01/24/23 at 9:13 AM. bed in no acute distre have an oxygen cam connected to a conce bed and was set to d The filter on the back completely white with An observation of Re 01/24/23 at 9:13 AM. bed in no acute distre have an oxygen cam connected to a conce bed and was set to d The filter on the back completely white with An observation of Re 01/24/23 at 4:34 PM. bed in no acute distre	rly Minimum Data Set (MDS) aled that Resident #11 was ly impaired for daily decision extensive assistance with g. The MDS further revealed ed oxygen and had no during the assessment esident #11 was made on A. Resident #11 was resting stress. She was observed to hula in her nose that was entrator sitting next to her eliver one liter of oxygen. a of the concentrator was in dust particles. esident #11 was resting in ess. She was observed to hula in her nose that was entrator sitting next to her eliver one liter of oxygen. a fully particles. esident #11 was resting in ess. She was observed to hula in her nose that was entrator sitting next to her eliver one liter of oxygen. a of the concentrator was			complete audits of at least 10 resident that have oxygen concentrators wee 4 weeks and monthly for 2 months to ensure residents' oxygen concentrate filters continue to be cleaned and the oxygen is being administered at the prescribed rate. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for revie ensure the facility's continued complete the facility's continued c	kly for ors e ue w to	
	bed and was set to d	entrator sitting next to her eliver one liter of oxygen. t of the concentrator was n dust particles.					
	An observation of Re 01/25/23 at 9:52 AM.	esident #11 was made on Resident #11 was resting in ess. She was observed to					

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345179	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	have an oxygen cann connected to a conce bed and was set to de The filter on the back completely white with An observation of Res 01/25/23 at 11:57 AM in bed in no acute dis have an oxygen cann connected to a conce bed and was set to de The filter on the back completely white with Nurse #6 was intervie AM who confirmed the Resident #11. Nurse a wore oxygen at two lift change the rate on he that the nurses should flow rate throughout the not checked Resident Nurse #6 entered Res confirmed that her co- one liter of oxygen an Nurse #6 returned the liters as ordered. She tubing and filters were shift. Nurse #6 also co- concentrator filter was cleaned or replaced. Nurse #5 was intervie at 2:01 PM. Nurse #5 worked the night shift that weekly they were change oxygen tubing	ula in her nose that was ntrator sitting next to her eliver one liter of oxygen. of the concentrator was dust particles. sident #11 was made on . Resident #11 was resting tress. She was observed to ula in her nose that was ntrator sitting next to her eliver one liter of oxygen. of the concentrator was dust particles. ewed on 01/25/23 at 11:59 at she was caring for #6 stated that Resident #11 ters and would not be able to er own. She further stated d be checking the oxygen heir shift but stated she had t #11's thus far on her shift. sident #11's room and ncentrator was set to deliver d should be on two liters. e oxygen flow rate to two added that the oxygen e cleaned weekly on night	F	695			

Facility ID: 922988

If continuation sheet Page 52 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED C	
		345179	B. WING				C 108/2023	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE OORESVILLE, NC 28115			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 695	stated she had never oxygen concentrator i they were responsible them. The Assistant Directo interviewed on 01/26/ that there had been s who was responsible oxygen concentrator i maintenance departm it was moved to the c back to the nursing de stated that oxygen tul weekly and as neede cleaned or replaced n that the nurses should flow rate at least once correct dose was bein should be cleaning or The Director of Nursin on 01/26/23 at 1:19 P oxygen cannulas wer needed and during th concentrator filters sh replaced. She stated the units to check the once on their shift and	as instructed. Nurse #5 looked at or cleaned an filter and was not aware that e for cleaning or changing r of Nursing (ADON) was 23 at 11:57 AM and stated ome miscommunication on for cleaning or replacing filters. At one point nent took care of them, then entral supply clerk, and then epartment. The ADON bing was changed at least d and the filters were nonthly. The ADON stated d be checking the oxygen e per shift to ensure the ng administered and they replacing filters as ordered. M and stated that the e changed weekly and as e same time the oxygen ould be cleaned or she expected the nurses on oxygen flow rate at least d document on the MAR to ct dose of oxygen was being		732			3/10/23	
SS=C	CFR(s): 483.35(g)(1)- §483.35(g) Nurse Sta §483.35(g)(1) Data re	-(4)		52			0/10/20	

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If continuation sheet Page 53 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345179	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 732	basis: (i) Facility name. (ii) The current date. (iii) The total number by the following categr unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practicar vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must post (A) Clear and readabl (B) In a prominent plaresidents and visitors §483.35(g)(3) Public as staffing data. The fact written request, maker available to the public exceed the communit §483.35(g)(4) Facilityrequirements. The far posted daily nurse staffing nurse staffing data. This REQUIREMENT by: Based on observation facility failed to post of based on observation facility failed to post of the facility failed to post of the facil	and the actual hours worked pories of licensed and aff directly responsible for t: I nurses or licensed defined under State law). des. g requirements. bost the nurse staffing data h (g)(1) of this section on a inning of each shift. red as follows: le format. dece readily accessible to access to posted nurse cility must, upon oral or e nurse staffing data c for review at a cost not to by standard.	F	732	The identified missing daily nurse staff information data sheets were complete by the Director of Nursing on 2/1/2023	ed	

Facility ID: 922988

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY _ETED
		345179	B. WING		-	,)8/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 732	The finding included: During the entrance in 9:18 AM, the daily po information was obse receptionist's desk ar An observation on 1/2 posted nurse staffing receptionist's desk in updated with the corrr An observation on 1/2 posted nurse staffing receptionist's desk in 1/23/23. During an interview w 1/24/23 at 1:36 PM he scheduling coordinate the posting was place thing in the morning a over the weekend. Attempts were made coordinator without su During an observation the front lobby recept daily posted nurse sta and the plastic frame	nto the facility on 1/23/23 at sted nurse staffing rved in the front lobby at the ad was dated 1/21/23. 23/23 at 4:00 PM of the daily information visible at the the front lobby had not been ectly dated form. 24/23 at 1:30 PM of the daily information visible at the the front lobby was dated with the Administrator on e explained that the or was assigned to ensure ad in the front lobby first and was left for staff to post to contact the scheduling	F 7		the ata ated to uuired. work work work work work ata dated he onths	
	An interview with the on 1/25/23 at 11:00 A had quit the day befo	Assistant Director of Nursing M revealed the scheduler re and he was going to he duty but was not familiar				

Facility ID: 922988

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/07/20 FORM APPROVE OMB NO. 0938-039		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345179	B. WING		02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDI	US HEALTH AT MOORE	SVILLE		52 E CENTER AVENUE IOORESVILLE, NC 28115			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 732	Continued From page	9 55	F 732				
F 757	1/26/23 at 3:00 PM re staff posting to be acc and staff at the recep	with the Administrator on evealed he expected the curate and visible to visitors tionist's desk each morning. e from Unnecessary Drugs	F 757		3/10/23		
SS=E	CFR(s): 483.45(d)(1) §483.45(d) Unnecess Each resident's drug	-(6)			0/10/20		
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including y); or					
	§483.45(d)(2) For exc	cessive duration; or					
	§483.45(d)(3) Withou	t adequate monitoring; or					
	§483.45(d)(4) Withou use; or	t adequate indications for its					
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be					
	stated in paragraphs section. This REQUIREMENT	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced					
	Practitioner, Nurse Pr Director interviews th Psychiatric Nurse Pra for medication chang	iew, staff, Psychiatric Nurse ractitioner, and Medical e facility failed to implement actitioner recommendations es and labs (blood draws)		Resident #42, Resident #43, and Resident #22 Psychiatric recommendations were reviewed by th Nurse Practitioner on 2/1/2023.	ne		
		viewed for unnecessary		All current residents who receive			

Event ID: TEQX11

Facility ID: 922988

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
	245170			С
	343179			02/08/2023
ROVIDER OR SUPPLIER				
US HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE COMPLETIO
Continued From page	e 56	F 75	57	
medications (Residen Resident #22). The finding included: 1. Resident #42 was 07/31/21 with diagno major depressive dis Review of a Depakot stabilize mood) level Resident #42's level milliliter (mcg/ml) whi reference range. Review of a physician Depakote Sprinkles f mouth give four caps Review of a quarterly dated 11/10/22 revea moderately impaired and required extensiv activities of daily livin that Resident #42 ha antipsychotic and and during the assessme Review of a Psychiat progress note dated complaint: Medication progress note listed F medications, current system. Orders and p	nt #42, Resident #43, and readmitted to the facility on ses that included dementia, order, anxiety, and insomnia. e (medication used to dated 09/23/22 revealed to be 75 micrograms per ch was in the therapeutic n order dated 09/24/22 read, 125 milligrams (mg) by ule two times a day. Minimum Data Set (MDS) and that Resident #42 was for daily decision making ve to total assistance with g. The MDS further revealed d received seven days of an tidepressant medication nt reference period. ric Nurse Practitioner (NP) 12/27/22 read in part, Chief n Management. The Resident #42's current diagnoses, and review of olan: check Depakote level,		 psychiatric services have the peraffected. An audit will be composite of the affected. An audit will be composite of the Director of Nursing(DON)/designee of the residents' psychiatric recommends for the last 60 days to ensure the up has been completed as required. The licensed nurses will be edual 3/9/2023 by the DON/ designee ensuring residents' who receives psychiatric services recommends being followed up as required. The licensed nurses to include licensed nurses will not be allow work until the education is complete the education. The Director of Nursing/ design complete audits of the residents' precommendations are being followed. The Director of Nursing will subfindings to the Quality Assurance Performance Improvement (QA committee monthly meeting for for review and follow up with 	leted by current indations inat follow inred. incation by e related to e related to dations are agency ved to obleted. to ee will s who nonthly for sychiatric lowed up mit the ce PI) 3 months
	DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER US HEALTH AT MOORE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page medications (Residen Resident #22). The finding included: 1. Resident #42 was 07/31/21 with diagno major depressive dis Review of a Depakot stabilize mood) level Resident #42's level milliliter (mcg/ml) whi reference range. Review of a physician Depakote Sprinkles f mouth give four caps Review of a quarterly dated 11/10/22 revea moderately impaired and required extension activities of daily livin that Resident #42 ha antipsychotic and and during the assessme Review of a Psychiat progress note listed F medications, current system. Orders and p	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179 345179 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 56 medications (Resident #42, Resident #43, and Resident #22). The finding included: 1. Resident #42 was readmitted to the facility on 07/31/21 with diagnoses that included dementia, major depressive disorder, anxiety, and insomnia. Review of a Depakote (medication used to stabilize mood) level dated 09/23/22 revealed Resident #42's level to be 75 micrograms per milliliter (mcg/ml) which was in the therapeutic reference range. Review of a physician order dated 09/24/22 read, Depakote Sprinkles 125 milligrams (mg) by mouth give four capsule two times a day. Review of a quarterly Minimum Data Set (MDS) dated 11/10/22 revealed that Resident #42 was moderately impaired for daily decision making and required extensive to total assistance with activities of daily living. The MDS further revealed that Resident #42 had received seven days of an antipsychotic and antidepressant medication during the assessment reference period. Review of a Psychiatric Nurse Practitioner (NP) progress note dated 12/27/22 read in part, Chief complaint: Medication Management. The progress note dated 12/27/22 read in part, Chief complaint: Medication Management. The progress note listed Resident #42's current medications, current diagnoses, and review of system. Orders and	IDENTIFICATION NUMBER: A. BUILDING A. BUILDING 345179 ROVIDER OR SUPPLIER US HEALTH AT MOORESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX Continued From page 56 medications (Resident #42, Resident #43, and Resident #22). F 75 The finding included: 1. Resident #42 was readmitted to the facility on 07/31/21 with diagnoses that included dementia, major depressive disorder, anxiety, and insomnia. F Review of a Depakote (medication used to stabilize mood) level dated 09/23/22 revealed Resident #42's level to be 75 micrograms per milliliter (mcg/ml) which was in the therapeutic reference range. Review of a physician order dated 09/24/22 read, Depakote Sprinkles 125 milligrams (mg) by mouth give four capsule two times a day. Review of a quarterly Minimum Data Set (MDS) dated 11/10/22 revealed that Resident #42 was moderately impaired for daily decision making and required extensive to total assistance with activities of daily living. The MDS further revealed that Resident #42 had received seven days of an antipsychotic and antidepressant medication during the assessment reference period. Review of a Psychiatric Nurse Practitioner (NP) progress note dated 12/27/22 read in part, Chief complaint: Medication Management. The progress note listed Resident #42's current medications, current diagnoses, and review of system. Orders and plan: check Depakote level,	PEFICIENCIES CORRECTON (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTON A BUILDING 345179 STREET ADDRESS, CITY, STATE, ZIP CODE CONTERSUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE CONTENT CONSTRUCTION REPRESENT CONSTRUCTION CONTENT CONSTRUCTION PROVIDERSY STATE, ZIP CODE CONTENT CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE CONTENT CONSTRUCTION CONTENT CONSTRUCTION CONTENT CONSTRUCTION PROVIDERSY STATE, ZIP CODE CONTENT CONSTRUCTION

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		D HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED	
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2023
ACCORD				7	752 E CENTER AVENUE		
ACCORD	IUS HEALTH AT MOORES	SVILLE		1	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 757	revealed no physiciar recommended by the further review of Resi revealed no lab result the platelet count. Th obtained on 12/30/22 The facility's Nurse P interviewed on 01/25/ she did not review the because she did not f was unsure of what th the PNP orders carrie she had only been at and they had new pro- December 2022. An interview with the Representative from 1 office was conducted 3:06 PM. She stated the electronic health reco visited with the reside their progress note th securely emailed the Director of Nursing (E Nursing (ADON)/ Adm the note was complet the facility staff to prin recommendations/ord their own electronic health A phone interview wa Psychiatric NP on 01/ stated that after she h and dictated her note	a orders for the labs Psychiatric NP on 12/27/22, dent #42's medical record is for the Depakote level or e NA level and LFP were ractitioner (NP) was 23 at 2:17 PM who stated e Psychiatric NP notes have access to them. She he process was for getting ed out and implemented as the facility since July 2022, ovider Psychiatric NP as of Customer Service the Psychiatric providers via phone on 01/25/23 at that the Psychiatric NP was I had only one visit to the at they had their own rd and once the provider int and the provider dictated eir electronic system facility staff usually the DON)/Assistant Director of ninistrator the midnight after ed. Then it would be up to at off the notes, carry out any lers and then upload into ealth record. s conducted with the f25/23 at 3:14 PM who had visited with the resident	F	757			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/07/2023 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345179	B. WING			C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	to the facility staff usu further stated that at t to be drawn within 10 were routine, and she next schedule visit. Th different for each resi 2-3 weeks, and some weeks. The Psychiatr ordered were abnorm staff to contact her. D checked for residents we also look at other function was within sa were not then she wo primary care physicia was not sure of the phy recommendation/orde stated sometimes the (MD) for approval and not. Either way she sh recommendations/orde facility staff and if the let her know. The MD was interview who stated that she v week and she no long psychiatric recomment facility's NP was in the stated she assumed to because she was no could not speak to the she no longer reviewed expected all orders at monitoring to be com The ADON was interview	ally the DON/ADON. She times she would order labs days but other times they would review them on her he next scheduled visit was dent some were seen every were seen every 4-6 tic NP stated that if the labs al, she would expect the epakote levels were that were on Depakote and labs that ensure organ afe parameter and if they uld refer the resident to their n for a workup. The PNP rocess once her ers arrived at the facility, she y go to the Medical Director d at other facility's they did tated she would expect her bers to be carried out by the re was an issue for them to wed on 01/25/23 at 5:10 PM isited the facility once a ger received or reviewed the hedations/orders because the e building every day. She he NP reviewed them longer getting them, she e process in the facility since ed them but stated she hod labs for medication	F	757				

Facility ID: 922988

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STATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIER (CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION 345179 B. WING C C NAME OF PROVIDER OR SUPPLIER 345179 STREET ADDRESS, CITY, STATE, ZIP CODE C 02/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TS2 E CENTER AVENUE CC 02/08/2023 ACCORDIUS HEALTH AT MOORESVILLE SUMMARY STATEMENT OF DEFICIENCIES BREFIX PROVIDER'S PLAN OF CORRECTION C PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX PROVIDER'S PLAN OF CORRECTION NULL BE COMPLETE F 757 Continued From page 59 that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility had a new provider and she had not yet come to the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated 't was my impression that if a consulting provider come to the facility and made recommendations they would be electronic medical record for and she had access to the edical located of at find, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way. F 757			ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
345179 B. WING 02/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115 V(A) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE DEFICIENCY) COMPLETIC DEFICIENCY F 757 Continued From page 59 that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated 'th was my impression that if a consulting provider come to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way. ID ID ID PREFIX PREFIX CONTINUE CONTINUE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` <i>`</i>			(X3) DATE COMF	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT MOORESVILLE STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OSI COMPLETK DEFICIENCY F 757 Continued From page 59 that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider come to the facility and ande recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way. ID PREFIX			345179	B. WING				-
ACCORDUS HEALTH AT MOORESVILLE MOORESVILLE, NC 28115 Image: Complexity of the second secon	NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	_ ·	
MOORESVILLE, NC 28115 Image: Continued From page 59 Image: Continued From page 59 Image: Continued From page 59 F 757 Continued From page 59 F 757 that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider come to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way.						752 E CENTER AVENUE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE F 757 Continued From page 59 that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider come to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way. EVALUATION STATE	ACCORDI	IUS HEALTH AT MOURES	SVILLE		1	MOORESVILLE, NC 28115		
that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility had a new provider and she had not yet come to the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider come to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
The DON was interviewed on 01/26/23 at 1:09 PM who stated she had only been at the facility for three weeks. She stated she had not received any recommendations/orders from the Psychiatric NP. She stated that typically those recommendations would come to the DON or NP for approval but again stated that she had not received any from the Psychiatric NP. The DON stated that she expected the recommendations/orders from the Psychiatric NP to be approved by the NP or MD and then entered and carried out by the facility staff within the week of receiving the recommendations. 2. Resident #43 was admitted to the facility on 01/17/20 with diagnoses that included dementia, major depressive disorder, anxiety, and insomnia. Review of a physician order dated 02/09/22 read, Depakote Sprinkles (medication used to stabilize mood) 125 milligrams (mg) by mouth give four	F 757	that he was unaware for processing the psy stated that the facility had not yet come to the that he was included received but the emain resident she saw it due recommendations/ord was my impression the come to the facility and they would be given the approval or not." He as out to the Psychiatric access to the electron he could give that to he own recommendations could approve them the The DON was intervise PM who stated she has for three weeks. She any recommendations NP. She stated that the recommendations wo for approval but again received any from the stated that she expect recommendations/ord to be approved by the entered and carried of the week of receiving 2. Resident #43 was a 01/17/20 with diagnos major depressive disc	of the process at the facility ychiatric progress notes. He had a new provider and she he facility. The ADON stated in the email that was il was just a summary of the d not include her notes or ders. The ADON stated "it nat if a consulting provider nd made recommendations to the Medical Director for added that he would reach NP and see if she had nic medical record and if not, her so she could enter her ns/orders and then the MD hat way. ewed on 01/26/23 at 1:09 ad only been at the facility stated she had not received s/orders from the Psychiatric ypically those ould come to the DON or NP in stated that she had not e Psychiatric NP. The DON sted the ders from the Psychiatric NP e NP or MD and then out by the facility staff within the recommendations. admitted to the facility on ses that included dementia, order, anxiety, and insomnia.	F	757	7		

Facility ID: 922988

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OMB NO. 0938-0391
(X3) DATE SURVEY COMPLETED
C 02/08/2023
CODE
F CORRECTION (X5) CTION SHOULD BE COMPLETION THE APPROPRIATE DATE

Facility ID: 922988

If continuation sheet Page 61 of 133

CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	0: 03/07/2023 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345179	B. WING				。 08/2023
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	VILLE		752 E CENTER AVENUE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	since July 2022, and PsychiatricNP as of D An interview with the Representative from to office was conducted 3:06 PM. She stated the new to the facility and facility. She stated the electronic health reco visited with the reside their progress note the securely emailed the Director of Nursing (D Nursing (ADON)/ Adm the note was complete the facility staff to prim recommendations/ord their own electronic he A phone interview was Psychiatric NP on 01/ stated that after she he and dictated her note recommendations/ord to the facility staff usua further stated that at to to be drawn within 10 were routine, and she next scheduled visit. different for each reside 2-3 weeks, and some weeks. The Psychiatri ordered were abnorm staff to contact her. D checked for residents	ders carried out and had only been at the facility they had new provider becember 2022. Customer Service he Psychiatric providers via phone on 01/25/23 at that the Psychiatric NP was I had only one visit to the at they had their own rd and once the provider nt and the provider dictated eir electronic system facility staff usually the ON)/Assistant Director of hinistrator the midnight after ed. Then it would be up to at off the notes, carry out any lers and then upload into ealth record. s conducted with the 25/23 at 3:14 PM who had visited with the resident along with her lers were electronically sent ally the DON/ADON. She imes she would order labs days but other times they e would review them on her The next schedule visit was dent some were seen every were seen every 4-6 ic NP stated that if the labs al, she would expect the	F 757				

Facility ID: 922988

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	MENT OF HEALTH AN	D HUMAN SERVICES					FORM): 03/07/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING					C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
				7	752 E CENTER AVENUE			
ACCORD	US HEALTH AT MOORES	SVILLE		Ν	MOORESVILLE, NC 2811	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 757	were not then she wo primary care physicia Psychiatric NP was no her recommendation/ she stated sometimes Director (MD) for app they did not. Either wa expect her recommer out by the facility staff for them to let her know The MD was interview who stated that she v week and she no long psychiatric recommer facility's NP was in the stated she assumed to because she was no could not speak to the she no longer review expected all orders at monitoring to be comp The ADON was interview AM who stated he has since the middle of Do that he was unaware for processing the psy stated that the facility had not yet come to th that he was included received but the email residents she saw it do recommendations/ord was my impression th come to the facility ar they would be given to	afe parameter and if they uld refer the resident to their in for a workup. The ot sure of the process once orders arrived at the facility, a they go to the Medical roval and at other facility's ay she stated she would idations/orders to be carried and if there was an issue ow. wed on 01/25/23 at 5:10 PM isited the facility once a ger received or reviewed the idations/orders because the e building every day. She he NP reviewed them longer getting them, she e process in the facility since ed them but stated she nd labs for medication oleted within a week. riewed on 01/26/23 at 11:23 d only been at the facility ecember 2022. He stated of the process at the facility ychiatric progress notes. He had a new provider and she ne facility. The ADON stated	F	757				

Facility ID: 922988

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/07/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING			_		C 08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	out to the Psychiatric access to the electron he could give that to h own recommendation could approve them the The DON was intervie PM who stated she has for three weeks. She any recommendations NP. She stated that ty recommendations wo for approval but again received any from the stated that she expect recommendations/ord to be approved by the entered and carried o the week of receiving 3. Resident #22 was a 02/27/18 with diagnos depressive disorder w depression, and Alzhe A review of Resident a revealed the last valp was obtained in June was low. A review of Resident a 12/27/22 revealed ord (antidepressant) 100 every day. *Valproic A stabilizer) 250 mg/5 n mouth twice a day. The quarterly Minimut	NP and see if she had hic medical record and if not, her so she could enter her s/orders and then the MD hat way. weed on 01/26/23 at 1:09 ad only been at the facility stated she had not received s/orders from the Psychiatric ypically those uld come to the DON or NP a stated that she had not e Psychiatric NP. The DON ted the lers from the Psychiatric NP e NP or MD and then ut by the facility staff within the recommendations. admitted to the facility on ses that included major <i>v</i> ith behavioral disturbances, eimer's disease. #22's medical record roic acid (Depakote) level 2022 at a level of 3 which #22's physician orders for ders for *Bupropion SR milligrams (mg) by mouth acid (Depakote) (mood hilliliters (ml) give 2.5 ml by	F	757				

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		ID HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER	L	I	;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ACCORD	IUS HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE		
ACCORD		SVILL		I	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 757	 #22 had severe cogni received 7 days of an antidepressant medic A review of Resident notes dated 12/27/22 review was for Medici included a summary of recommendations (th *Change Depakote to morning and 500 mg in 7 days. *Decrease mouth every day for 1 The summary was ele Psychiatric Nurse Prational A review of Resident 01/24/23 revealed the changes or lab work of Psychiatric review. A review of Resident Medication Administra Resident received Bu mouth every day and give 2.5 ml by mouth On 01/25/23 at 3:06 F conducted with the C Representative expla their own electronic h providers do their visi their system securely facility staff which wa: Nursing, Assistant Din Administrator, the nig 	 itive impairment and antianxiety and antianxiety and sation. #22's Psychiatry progress revealed the reason for al Management. The notes of the visit and e orders/plan) were to: 250 milligrams mg every every bedtime, check level Bupropion SR to 100 mg by 14 days then discontinue. ectronically signed by the actitioner. #22's medical record on ere were no medication results related to the #22's January 2023 ation Record revealed the propion SR 100 mg by Valproic Acid 250 mg/5 ml twice a day. PM an interview was 	F	757			

Facility ID: 922988

If continuation sheet Page 65 of 133

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 345179 B. WING 02/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE 752 E CENTER AVENUE MOORESVILLE, NC 28115 MOORESVILLE, NC 28115 (X3) DATE SURVEY			ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/07/2023 MAPPROVED). 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT MOORESVILLE STREET ADDRESS, CITY, STATE, ZIP CODE (x4),ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) (x00 COMPLET DEFICIENCY) F 757 Continued From page 65 upload the notes into their system by the process they have developed. F 757 On 01/25/23 at 3:14 PM an interview was made with the Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations and determine if they wished to carry them out or not. The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer Image: Complexity of Complexity of Complexity certific the facility once a week and she no longer Image: Complexity of Complexity certific the psychiatric Complexity of Complexity certific the facility once a week and she no longer Image: Complexity of Complexity certific the psychiatric Complexity Image: Complexity of Complexity certific the psychiatric Complexity of Complexity certific to the psychiatric Complexity of Complexity Image: Complexity of Complexity certorecomplexity of Complexity Image: C	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY LETED
752 E CENTER AVENUE MOORESVILLE, NC 28115 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X3) COMPLET DATE F 757 Continued From page 65 upload the notes into their system by the process they have developed. F 757 F 757 On 01/25/23 at 3:14 PM an interview was made with the Psychiatric Nurse Practitioner (NP) who conducted Resident #22's Psychiatry visit on 12/27/22. The Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations and determine if they wished to carry them out or not. The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the Psychiatric			345179	B. WING				
ACCORDUS HEALTH AT MOORESVILLE MOORESVILLE, NC 28115 (K4) 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 ODRRECTIVE ACTION SHOLD BE DEFICIENCY) COMMENT DEFICIENCY F 757 Continued From page 65 upload the notes into their system by the process they have developed. F 757 On 01/25/23 at 3:14 PM an interview was made with the Psychiatric Nurse Practitioner (NP) who conducted Resident #22's Psychiatry visit on 12/27/22. The Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations and determine if they wished to carry them out or not. The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the Psychiatric	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETM DATE F 757 Continued From page 65 upload the notes into their system by the process they have developed. F 757 F 757 On 01/25/23 at 3:14 PM an interview was made with the Psychiatric Nurse Practitioner (NP) who conducted Resident #22's Psychiatry visit on 12/27/22. The Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing vassistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations only and expected the Medical Director to review her summary and recommendations and determine if they wished to carry them out or not. The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the Psychiatric	ACCORDI	US HEALTH AT MOORES	SVILLE			115		
upload the notes into their system by the process they have developed. Image: Construct of the process they have developed. On 01/25/23 at 3:14 PM an interview was made with the Psychiatric Nurse Practitioner (NP) who conducted Resident #22's Psychiatry visit on 12/27/22. The Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations only and expected the Medical Director to review her summary and recommendations and determine if they wished to carry them out or not. The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the Psychiatric	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE INCED TO THE APPROPRIA		COMPLETION
NP was in the building every day. She stated she assumed the NP reviewed them because she was no longer getting them, she could not speak to the process in the facility since she no longer reviewed them but stated she expected all orders and labs for medication monitoring to be completed within a week. On 01/25/23 at 2:17 PM during an interview with the facility's Nurse Practitioner (NP) she explained that she had only been employed since July 2022 and she did not review the psychiatric progress notes because she did not have access to them. The NP stated she did not know what the process was for getting the psychiatric orders	F 757	upload the notes into they have developed. On 01/25/23 at 3:14 F with the Psychiatric N conducted Resident # 12/27/22. The Psychi summary of her visit a recommendations wa Director of Nursing or Nursing via email and Director of Nursing wa facility. The Psychiatr that she wrote recommendations expected the Medical summary and recommendations/or 01/25/23 at 5:10 PM was the facility once a wear received or reviewed recommendations/or NP was in the building assumed the NP reviewas no longer getting to the process in the facility's Nurse Pra- explained that she ha July 2022 and she dic progress notes becau- to them. The NP state	their system by the process PM an interview was made urse Practitioner (NP) who 422's Psychiatry visit on atric NP explained that the along with her orders or s sent electronically to the Assistant Director of I in this case the previous as still employed by the ic NP continued to explain mendations only and Director to review her nendations and determine if hem out or not. was interviewed on who stated that she visited ek and she no longer the Psychiatric lers because the facility's g every day. She stated she ewed them because she them, she could not speak facility since she no longer ated she expected all orders on monitoring to be eek. PM during an interview with actitioner (NP) she d only been employed since at on treview the psychiatric les she did not have access ad she did not know what	F 757				

Facility ID: 922988

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FORM	03/07/2023 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE SI COMPLE	JRVEY
	345179	B. WING			C 02/08	3/2023
NAME OF PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
		7	252 E CENTER AVENUE			
ACCORDIUS HEALTH AT MOORE	SVILLE	N	MOORESVILLE, NC 281	15		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 757 Continued From page orders carried out.	≥ 66	F 757				
Nursing (ADON) on C only been at the facilit December 2022 and process at the facility processing the psych stated that the facility had not yet come to the continued to explain the email that was receive summary of the resid not include in her not recommendations/or was my impression the came to the facility and they would be given the approval or not." He and out to the Psychiatric access to the electron he could give that to own recommendation Medical Director could On 01/26/23 at 1:00 fl conducted with the pi who explained that the summaries and reconvisits were sent elect stated they were only reviewed by the Med Practitioner and if the process the recommendations the process the recommendations the process the recommendations the process the recommen	ders. The ADON stated "it nat if a consulting provider nd made recommendations to the Medical Director for added that he would reach NP and see if she had nic medical record and if not, he so she could enter her is/orders and then the d approve them that way. PM an interview was revious Director of Nursing the Psychiatric NP's mmendations from their ronically to the facility. She recommendations that were ical Director or Nurse					

Facility ID: 922988

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345179	B. WING				C /08/2023
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 757	received any recomm Psychiatric NP. She s recommendations wo for approval but again received any from the stated that she expect recommendations/ord to be approved by the entered and carried o the week of receiving Free from Unnec Psy CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behav but are not limited to, categories: (i) Anti-depressant; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio	three weeks and had not endations/orders from the stated that typically those uld come to the DON or NP is stated that she had not Psychiatric NP. The DON ted the ers from the Psychiatric NP is NP or MD and then ut by the facility staff within the recommendations. chotropic Meds/PRN Use (e)(1)-(5) pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that ints who have not used re not given these drugs is necessary to treat a diagnosed and documented ints who use psychotropic i dose reductions, and		757			3/10/23
	drugs receive gradual behavioral interventio	l dose reductions, and ns, unless clinically					

Facility ID: 922988

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						NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		ATE SURVEY OMPLETED
			A. BOILDING			С
		345179	B. WING			02/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
	US HEALTH AT MOORE	SVII I E		752 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOURE	JVILLE		MOORESVILLE, NC 28115		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 758	Continued From page drugs;	9 68	F 75	58		
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ondition that is documented				
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PF beyond 14 days, he c	RN order to be extended or she should document their ent's medical record and				
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT	er evaluates the resident for				
	Nurse Practitioner, N Medical Director inter implement Psychiatry psychotropic medicat	iews and staff, Psychiatric urse Practitioner and views the facility failed to recommendations for ion changes for 1 of 5 r unnecessary medications		Resident #22 Psychiatric recommendations for psychol medication changes were rev Director of Nursing on 3/9/202 orders were updated as requi All current residents who rece psychiatric services have the affected. An audit will be com	iewed by the 23 and red. vive potential to	
	The findings include:			3/9/2023 by the Director of Nursing/designee of the curre	nt residents'	
	02/27/18 with diagnos	mitted to the facility on ses that included major vith behavioral disturbances, eimer's disease.		psychiatric recommendations 60 days to ensure psychotrop medication changes have bee as required.	ic	

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					OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345179	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORD	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTIO
F 758	Continued From page	e 69	F 75	8	
	A review of Resident revealed an order da	#22's physician orders ted 06/01/22 for Seroquel ligrams (mg) by mouth twice essive Disorder with ces.		The licensed nurses will be educe 3/9/2023 by the DON/ designee ensuring residents' who receive psychiatric services psychotropic medication changes are being co as required.	related to
	assessment dated 12 #22 had severe cogn received 7 days of an	2/21/22 revealed Resident		The licensed nurses to include a licensed nurses will not be allow work until the education is complete the education.	ed to leted.
	notes dated 12/27/22 review was for Medic included a summary recommendations (th *Decrease Seroquel mouth every bedtime	revealed the reason for al Management. The notes of the visit and e orders/plan) were to: (antipsychotic) to 25 mg by		The Director of Nursing/ designe complete audits of the residents received psychiatric services mo 3 months to ensure residents' psychotropic medication change being completed as required.	who onthly for s are
	01/24/23 revealed the changes related to the A review of Resident Medication Administra	-		The Director of Nursing will subn findings to the Quality Assurance Performance Improvement (QAF committee monthly meeting for 3 for review and follow up with recommendations to ensure the continued compliance.	e PI) 9 months
	Services utilized by the explained that their constrained that their constrained that their constraints and the dotheir visits and dotheir visits	ustomer Service) with the Psychiatric he facility. The CSR ompany had their own ord and once their providers tate their notes their system notes to the facility staff			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) D	ATE SURVEY OMPLETED
		345179	B. WING				C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 758	Assistant Director of I Administrator, the nig done. Then it was the upload the notes into they have developed. On 01/25/23 at 3:14 F with the Psychiatric N conducted Resident # 12/27/22. The Psychi summary of her visit a recommendations wa Director of Nursing or Nursing via email and Director of Nursing wa facility. The Psychiatri that she wrote recommendations expected the Medical summary and recommendations/or 01/25/23 at 5:10 PM w the facility once a wear received or reviewed recommendations/or NP was in the building assumed the NP reviewas no longer getting to the process in the facility's Nurse Pra- explained that she has July 2022 and she did	Nursing and or the ht after the notes were efacility's responsibility to their system by the process PM an interview was made lurse Practitioner (NP) who #22's Psychiatry visit on atric NP explained that the along with her orders or s sent electronically to the * Assistant Director of I in this case the previous as still employed by the ic NP continued to explain mendations only and Director to review her nendations and determine if hem out or not. Was interviewed on who stated that she visited ek and she no longer the Psychiatric ders because the facility's g every day. She stated she ewed them because she them, she could not speak facility since she no longer ated she expected all orders on monitoring to be eek.	F	758	Β		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED C
		345179	B. WING				08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			/52 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	the process was for g into the residents' ele orders carried out. On 01/26/23 at 1:00 F conducted with the pr who explained that th summaries and recom visits were sent electr stated they were only reviewed by the Medi Practitioner and if the recommendations the process the recommendations change them as they The Director of Nursir on 01/26/23 at 1:09 P been at the facility for received any recommendations wo for approval but again received any from the she expected the reco the Psychiatric NP to MD and then entered facility staff within the recommendations.	ed she did not know what etting the psychiatric orders ctric health record or the PM an interview was evious Director of Nursing e Psychiatric NP's mendations from their ronically to the facility. She recommendations that were cal Director or Nurse y approved the en they were responsible to endations as orders or deemed appropriate. ng (DON) was interviewed M who stated she had only three weeks and had not endations/orders from the stated that typically those uld come to the DON or NP a stated that she had not e PNP. The DON stated that pommendations/orders from be approved by the NP or and carried out by the week of receiving the	F	758			
F 802 SS=K		•	F	802			3/10/23
	appropriate competer out the functions of th	loy sufficient staff with the ncies and skills sets to carry e food and nutrition service, ion resident assessments,					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/07/202 FORM APPROVE OMB NO. 0938-039		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345179	B. WING _		C 02/08/2023		
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
				752 E CENTER AVENUE			
ACCORDI	US HEALTH AT MOORES	SVILLE		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 802	and diagnoses of the in accordance with the required at §483.70(eff §483.60(a)(3) Support The facility must prove personnel to safely and functions of the food at §483.60(b) A member Services staff must part interdisciplinary team (2)(ii). This REQUIREMENT by: Based on staff interve facility failed to have a ensure there were diagnost when dietary staff did 1/22/23. The Central Nurse Aides (NAs) pr and dinner resident m internal temperature of serving and did not se altered diets as order likelihood for resident aspiration. This situat (Resident #1, Reside Resident #69, Resider 3 of 3 meals. The sta- lunch, and dinner res checking the internal foods before serving The Immediate Jeopa when dietary staff did	re and the number, acuity facility's resident population e facility assessment e). rt staff. ide sufficient support and effectively carry out the and nutrition service. r of the Food and Nutrition articipate on the as required in § 483.21(b) is not met as evidenced iews and record reviews, the effective systems in place to etary staff to prepare meals not arrive to work on the Supply Clerk and three epared breakfast, lunch, heals without checking the of cooked foods before erve resident mechanically ed. This led to the high is to be at risk of choking or tion affected 9 of 9 residents in #22, Resident #53, ent #31, Resident #57, at #17, and Resident #26) for ff also prepared breakfast, ident meals without temperature of cooked for 91 of 91 residents. ardy (IJ) began on 1/22/23 not arrive to work their	F 8	Resident #1, Resident #2 Resident #1, Resident #2 Resident #69, Resident #3 #57, Resident #8, Resident Resident #26 were assess or aspiration by the Direct 2/3/2023 with no changes noted. Residents 91 0f 91 were a the Director of Nursing/ de 2/3/2023 with no signs or food borne illness noted. All current residents have affected. The Administrator was ed 2/4/2023 and 3/2/2023 by Nursing Officer related to dietary department is suffi and appropriate food and competencies have been	22, Resident #53, 31, Resident nt #17, and sed for choking or of Nursing on in condition also checked by esignee on symptoms of the potential to ucated on the Chief ensuring the iciently staffed nutritional completed.		
	-	sure meal service was		The Dietary Manager will	be education by		

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	OF DEFICIENCIES				CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			· · ·	E SURVEY IPLETED	
			A. DOILDIN			с		
		345179	B. WING			0	2/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				75	52 E CENTER AVENUE			
ACCORD	IUS HEALTH AT MOORE	SVILLE		M	OORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
F 802	Continued From pag	e 73	F 8	02				
		and competent staff. This			3/9/2023 by the Administrator related t	O		
		idents not receiving a pureed			ensuring the dietary department is			
		The immediate jeopardy			sufficiently staffed and appropriate foo	d		
	was removed on 2/7/	/23 when the facility			and nutritional competencies have bee			
	· ·	ble allegation of immediate			completed.			
		ne facility will remain out of						
		scope and severity "E" (no			The dietary staff to include agency die			
		nmediate jeopardy) to ensure			staff will not be allowed to work until th			
	monitoring systems a effective.	are put into place are			education is completed. New hires als will be required to complete the educa			
	Findings included:				The Administrator/ designee will review			
					the dietary staff schedule during morni			
	An interview with the	Central Supply clerk was			meeting as well as the weekend sched			
	conducted on Sunda	y, 1/24/23 at 1:30 PM. The			each Friday for 3 months to ensure the	e		
		indicated he was working in			dietary department is adequately staff.			
	-	3 as a medication aide when						
		staff discovered the meal			The Administrator will submit the findir			
		st meal had not arrived at the			to the Quality Assurance Performance			
		around 8:45 AM. He indicated			Improvement (QAPI) committee mont	niy		
		ays should begin arriving on 7:30 AM each morning. The			meeting for 3 months for review and follow up with recommendations to en-			
		stated he, along with Nurse			the facility's continued compliance.	Suie		
		dietary department and			the lability s continued compliance.			
		he door. They discovered						
		lights on and both doors						
		I. Following this observation,						
		lerk notified the Administrator						
		t no dietary staff had arrived						
	to prepare food for th							
		d him, NA #5, NA #10, and						
		aster key to enter the dietary pare the breakfast meal.						
		explained since he and NA						
		kitchen during employment						
		s, they went to the walk-in						
		ezer and began pulling						
		vere normally served to the						
	residents for the brea	akfast meal and began						

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		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	TE SURVEY MPLETED	
	CONTRECTION	IDENTIFICATION NOWDER.	A. BUILDING	3	001		
					С		
		345179	B. WING	• • • • • • • • • • • • • • • • • • • •	0	2/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	CODE		
		·•• /// / =		752 E CENTER AVENUE			
ACCORD	US HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION	
F 802	Continued From pag	e 74	F 80	12			
		ok. He stated the following and cooked: omelets,					
		meal, grits, scrambled eggs,					
		ks. The Central Supply clerk					
		unable to puree food, so they					
		eces and then mashed it with					
	a potato masher to s						
		diets such as chopped or					
		uree. The Central Supply					
		kets had already been printed					
		to serve items based on the					
		hey did not call the Dietary					
		Dietary Manager nor the					
		d Dietician when the menu					
		t them know they were					
		itchen equipment. Central					
		d the breakfast meal was					
		for residents shortly after 10					
		cknowledged he and the					
		d the best they could and did					
		res of the food before					
		the proper textured diets for					
		Central Supply clerk indicated					
		30 AM, a dietary aide					
		ved to work who attempted					
	• • •	staff to wash dishes in the					
		ver, no one checked to					
		ures were meeting required					
		during usage. The Central					
		e and NA #11 also used the					
		ook wear but did not perform					
		ntrols to ensure proper levels					
		sed to maintain sanitation.					
	The Central Supply of	clerk further explained no one					
		department arrived to assist					
	on 1/22/23 and there						
	prepared all meals for	or residents on that day. He					
		-					
	stated they prepared	and served the following:					

Facility ID: 922988

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345179	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 802	they served: meatload casserole, mandarin of An interview with the conducted on 1/23/23 Administrator indicate from the dietary depa work on the morning 8:45 AM when nursin supply clerk discovered delivered to the units received their breakfa been delivered beginn indicated he lived out facility as soon as he gave the authorization Clerk and the 3 nurse NA #11) to begin mea the breakfast meal. H several hours later the PM on 1/22/23 at whi had already been ser Administrator indicate Dietary Consultant aff DM on 1/22/23 but wa providing staff to cove facility. The Administr food service experien Supply clerk to serve residents' meal ticket any further guidance service. He did not gip preparing snacks at the A telephone interview conducted on 1/26/23 revealed he had work	d cornbread and for supper f, mashed potatoes, squash branges, and a biscuit. Administrator was a at 12:30 PM. The ad he became aware staff rtment had not arrived at of 1/22/23 at approximately g staff and the central ed no meal trays had been and no residents had ast meal which should have hing at 7:30 AM. He of state came back to the could. The Administrator in for the Central Supply aides (NA #5, NA #10, and il preparation and delivery of e arrived at the facility at day between 2:00-3:00 ch time breakfast and lunch wed to all residents. The ed he contacted the Regional ter being unable to reach the as not assisted with er the meal delivery in the ator did not have previous ce and told the Central meals based on the but was unable to provide on preparation or meal we any directive regarding he time.	F	802			

Facility ID: 922988

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		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:					PLETED
			D MINO				С
		345179	B. WING			02/	08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE		
ACCORD	IUS HEALTH AT MOORES	SVILLE			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 802	Continued From page contact the DM by tel he followed the call w would alert the DM he scheduled shift of 5:3 Cook #1 stated he ha facility to answer any was to be prepared o equipment on 1/22/23 return call from the D verify that they freque dietary aides schedul weekends. A review of the month the following for 1/22/ Cook #1 was assigne Dietary Aide #1 was a 2:30 PM. Dietary Aide #2 was a 7:30 PM. A review of the month reflected this was the on Sunday and on the one cook would be so PM and an additional work from 12:30 PM the An interview with Diet conducted on 1/25/23 indicated she was sol morning of 1/22/23; h around 3 AM that she her scheduled shift for she initially called the then followed it with a and did not receive a	e 76 ephone without success so with a text message which e could not work his 0 AM to 5 PM on 1/22/23. In the second of the second by the questions about what food r how to use the kitchen 3 and did not receive a M. Cook #1 was also able to ently only had 1 cook and 2 ed to work on the hy dietary schedule revealed (23: ed from 5:30 AM to 5:00 PM. assigned from 10:30 AM to assigned from 10:30 AM to hy dietary scheduled schedule every other week e opposite Sunday revealed cheduled from 5:30 AM to 2 cook would be scheduled to to 7:30 PM. tary Aide #1 (DA) was a t 11:30 AM. DA #1 heduled to work on the owever, informed the DM e would not be able to work or that day. The DA #1 stated a text message on 1/22/23		802	DEFICIENCY)		

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/07/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING					C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
	US HEALTH AT MOORES			75	52 E CENTER AVENUE			
ACCORDI	US HEALIN AT MOORE			Μ	IOORESVILLE, NC 2811	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
F 802	works with the contract An interview with NA is revealed she arrived to 7:00 AM and she alor members began notion not been delivered and stated the Central Sup in the kitchen and beg she and NA #5 plated drinks and desserts b each unit. NA #10 sta both breakfast and lun aide in the evening m scheduled to leave at they were not able to equipment and therefor mechanically alter the up items really small a masher to get the foo before delivering it to reviewed the items lis Central Supply clerk's	erss. ermade to contact the ccess as she no longer cted food service company. # 10 on 1/24/23 at 1:59 PM to work on 1/22/23 at around og with other nursing staff ing residents' meals had ound 8:30 AM. NA #10 oply clerk and NA #11 went gan cooking the food and additional items such as efore they were delivered to ted she assisted to serve nch on 1/22/23, but did not eal because she was 4:00 PM. NA #10 explained use all of the kitchen ore attempted to e puree diet trays by cutting and then using a potato d as smooth as possible the residents. NA #10 ted that were served to the a list and agreed those were	F	802	DE	EFICIENCY)		
	wear was used becau trays. NA #10 also inc	that single use disposable use of lack of dishes and licated during the lunch						
	meal a few pizzas we	re ordered by a staff 's delivered were too hard						
		d they instead consumed						
	the meal served by th prepared the meal that	e nursing staff who						
	revealed she was ass	#5 on 1/25/23 at 10:30 AM igned to work the unit as a when she learned the						

Facility ID: 922988

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/07/2023 APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345179	B. WING			-		C 08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
	US HEALTH AT MOORES			7	752 E CENTER AVENUE				
ACCORDI	US REALTH AT MOORES	SVILLE		Ν	MOORESVILLE, NC 281	15			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 802	residents had not yet AM. NA #5 indicated s Supply clerk (who wa medication aide on 1/ went to the kitchen ar ready so residents co NA #5 stated they did residents something t acknowledged she wa to use the kitchen equ alter the foods for res therefore those items mashed with a potato consistency as possit were delivered on sin NA #5 recalled provid provided by the Centr interview. An interview with NA revealed he was sche aide on 1/22/23 when department had not a prepare meals to the the Central Supply cle obtained a key to enter where he and the Cen realized they each ha experience and there were the staff member items while NA #5 and items such as dessert they were not able to and therefore they we prepare the texture for therefore cut the item	a had not arrived to work and had breakfast at around 9 she along with the Central s assigned to work as a 22/23), NA #10, and NA #11 nd began getting breakfast uld have something to eat. the best they could to get o eat although she as aware they were unable uipment to mechanically idents on a puree diet and were cut up finely and masher to get as best ole and all meals served gle serve disposable wear. ing residents the food items ral Supply clerk during his #11 on 1/25/23 at 10:45 AM eduled to work as a nurse he was notified the dietary rrived at the facility to residents. NA #11 stated he, erk, NA #5, and NA #10 then er the dietary department htral Supply clerk had d some previous culinary fore they the two of them ers who prepared the food d NA #10 plated additional ts and drinks. NA #11 stated use the kitchen equipment ere unable to properly r the puree consistency and s up as small as possible	F	802		EFICIENCY)			
	therefore cut the item	s up as small as possible m with a potato masher							

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DEPARTMENT OF HEAI CENTERS FOR MEDICA						FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION		SURVEY PLETED		
		345179	B. WING			02/08/2023		
NAME OF PROVIDER OR SUPPL	IER		•	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDIUS HEALTH AT M	OORE	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
PREFIX (EACH DE				IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
they did not fol looked in the w find items that prepared the fol breakfast were oatmeal, grits, lunch: roast be spinach, peach they served: m casserole, man An interview w was conducted indicated she w facility Adminis from the dietar prepare food of staff were atten residents in the she was unsur than the staff of An interview w on 1/24/23 at 9 a phone over t the events of 1 when she was Regional Dieta come to the fa service and was what occurred provided the si verified it was scheduled in the A follow-up inter	ee diet low a r valk-in- were a bllowing : scran French ef, swe eatloat id arin o ith the l on 1/2 vas col trator v y depa n 1/22, mpting e facilit e at the id n the :28 AM ne wee /22/23 asked ry Con cility or is unsu in the o accura ne depa erview ry Mar	s. NA #11 acknowledged menu on 1/22/23; they strictly fridge and walk-in-freezer to accessible and verified they g items for residents for nbled eggs, omelets, n toast, and sausage; for eet potato casserole, d cornbread and for supper f, mashed potatoes, squash oranges, and a biscuit. Regional Dietary Consultant 23/23 at 10:08 AM. She ntacted on 1/22/23 by the who notified her that the staff rtment had not shown up to /23 and that facility nursing to prepare meals for all y. The Consultant indicated e time what occurred further	F	802				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345179	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER		1	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 802	dietary cook had mac aware on 1/21/23 tha work his shift on 1/22 when the DM was ma ensured coverage was staff. A telephone interview Registered Dietician (1/25/23 at 9:27 AM. S involved in dietary sta alterations in the facil contacted regarding t nursing staff on 1/22/ The Administrator wa Jeopardy on 2/3/23 a The facility provided t allegation of compliar of 2/7/23. The facility provided t allegation of compliar of 2/7/23. The facility those recipi are likely to suffer, a a result of the noncor The facility failed to e and competent staff v preparation and servi	le the Dietary Manager (DM) t he would not be able to /23 and further indicated ade aware, she should have as obtained with other dietary with the Consulting (CRD) was conducted on She stated she was not affing, schedules, or menu ity and had not been he foods to be prepared by 23. s notified of the Immediate t 9:14 AM. he following credible nee with a compliance date ents who have suffered, or serious adverse outcome as inpliance nsure adequately trained	F	802			
	and 3 Nurse aides pro residents when the so	ained Central supply Clerk epared 3 meals for 91 of 91 cheduled dietary staff did not n addition, the one untrained					

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	-	ID HUMAN SERVICES				FORI	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MU	TIDI	E CONSTRUCTION		D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
							С
		345179	B. WING			02	/08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORE	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID					PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
					DEFICIENCY)		
F 000		04	_				
F 802	Continued From page		F	802	2		
		and 3 Nurse aides prepared esidents without taking food					
	temperatures, withou	t being trained on the use of					
		l unaware of the 3-sink					
		nitization procedure. As a tagging the state stat					
	dish machine was no	t working properly, and					
	dishes were not sanit	ized as required.					
	On 2/3/23 the Directo	or of Nursing, Assistant					
	Director of Nursing, a						
	completed assessme residents to include the	nts of the current facility					
		main in the facility. No					
		odborne illnesses were					
	identified.						
	On 2/3/23, the curren	t facility residents were					
		ctor of Nursing and Assistant					
	-	identify any changes of nsafe food preparation and					
		tary restrictions and diets.					
	The require of this foi	ilium immented all 01 af the					
	facility residents on 1	ilure impacted all 91 of the //22/2023.					
	-						
	The current residents deficient practice.	are at risk as a result of this					
	dencient practice.						
		he entity will take to alter the					
		lure to prevent a serious n occurring or recurring, and					
	when the action will b						
	Starting 2/3/23. the n	ursing staff will be educated					
	by the Director of Nur	sing/ designee related to					
		and symptoms of foodborne					
	minesses. The educat	ion will continue at the					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
					752 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORES	SVILLE		1	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODUCTIVE ACTION SHOU					(X5) COMPLETION DATE
F 802	beginning of each shi receives the educatio member including age be permitted to work to received. Starting 2/3/23, the fa by the Director of Nur of Nursing to call the Dietary Manager imma available to prepare in dietary staff to include scheduled off, dietary staff from other sister prepare, cook, and se The Administrator and contact information w station. The Dietary Administrator will hav information to include contact information to dietary call out when building. The Administrator and review the dietary sta schedule during morr dietary department is Friday, the Administrator will review the weeke to ensure any staffing addressed. By 2/5/2023, the Dietary Administrator and the information will be po	ft until each staff member n by 2/6/2023. No staff ency staff and new hires will until the education is acility staff will be educated sing and Assistant Director Administrator and the rediately if dietary staff is not neals to ensure trained e dietary staff that are contract staff, and dietary facilities can be called in to erve the meals by 2/6/2023. If the Dietary Manager ill be posted at each nursing Manager and the e the dietary staff contact o ther sister facilities o assist with managing they are in or out of the d the Dietary Manager will ffing weekly and monthly sing report to ensure that the adequately staff. On each ator and the Dietary Manager ind dietary staffing schedule in concerns have been ary Manager to include the lucated by the Administrator	F	802	2		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 802	dietary manager and information in addition	e 83 he dietary staff has the the administrator's contact n to calling the facility if they he contact information.	F	802			
		implementation of this emoval for this alleged					
F 804 SS=E	with a completion date through staff interview training records. Staff demonstrate example serve meals, read me residents received the as ordered, able to ide foodborne illness and receiving the incorrect consumption. Each w were to report anytime staff were not present of day shift to the Adm of Nursing to include Nutritive Value/Appea	e correct consistency of diet entify symptoms of a potential risk of a resident t texture of food for ere able to verbalize they e the dietary department t in the building by the start ninistrator and the Director weekends. rr, Palatable/Prefer Temp	F	804			3/10/23
	§483.60(d)(1) Food p conserve nutritive val	es and the facility provides- repared by methods that ue, flavor, and appearance; nd drink that is palatable,					

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING			C 08/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				752 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORES	SVILLE		MOORESVILLE, NC 28115		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 804	by: Based on observation resident, and staff inter provide palatable food temperature and textur reviewed with food co Resident #12, Resider Resident #35). The findings included a. Resident #9 was an 09/13/22. Review of the quarter dated 11/11/22 reveal cognitively intact for do required set up assist An observation and in with Resident #9 on 00 Resident #9 was in hi front of him. The mea hot plate and there wa off his food tray that of rice, carrots, and an et that his food was "luk "ok" he indicated that eat enough to get full. the past he had askee and it took so long to not ask again.	is not met as evidenced ns, record review, test tray, erview's the facility failed to d that was appetizing in ure for 5 of 5 residents oncerns (Resident #9, nt #27, Resident #30, and : dmitted to the facility on ly Minimum Data Set (MDS) ed that Resident #9 was laily decision making and ance with eating.	F 8		I be cerns by the ential to urrent 2023 by sure re and ed by sure re and / lated the n dietary I the also ucation.	
		ly Minimum Data Set (MDS) led that Resident #12 was		served at the required temperature ordered texture.	and	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		PLETED
		345179	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (/08/2023
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 804	Continued From page	985	F 80	4		
	cognitively intact for c required set up assist	laily decision making and ance with eating.		The Administrator/ Dietary submit the findings to the (Assurance Performance Ir	Quality	
		nterview were conducted		(QAPI) committee monthly	meeting for 3	
		01/26/23 at 12:57 PM. her room with her lunch tray		months for review and follo recommendations to ensur	-	
	in front of her. The me	eal plate was not served on		continued compliance.		
		the cover was removed team coming off the food				
	and the plate was coo					
		fried rice, carrots, and an 2 stated that her food was				
		shy and over cooked. She				
		e enjoyed the meal much				
		been warm or even hot but f the meals in the facility				
	were cold and she ha	d gotten used to eating cold				
		nally Resident #12 stated				
	nourishment room an	ood out of the freezer in the difference of the				
		could not eat the cold food				
	c. Resident #27 was a 08/21/13.	admitted to the facility on				
	dated 11/08/22 revea cognitively intact for c	ly Minimum Data Set (MDS) led that Resident #27 was laily decision making and				
	required set up assist	ance with eating.				
	with Resident #27 on	nterview were conducted 01/26/23 at 1:00 PM. her room with her meal tray				
		eal plate was not served on				
	a hot plate and when was no visible steam	the lid was removed there noted and the plate was nt #27 stated that her food				
		d anticipated it to be better				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345179	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 804	as it was the resident month." Resident #27 meals served in the fa last month or, so they containers and they " everything was cold b the residents. She ad complained several ti and staff, and nothing d. Resident #30 was 1 01/21/20. Review of the quarter dated 11/03/22 revea moderately cognitivel making and required eating. An observation and ir with Resident #30 on Resident #30 was in l in front of her. The mo a hot plate and when no visible steam, and Resident #30 began t consisted of shrimp a carrots, and an egg ro was cold, and the rice stated that rice was o when at home ate rice this rice was overcool not sure how much sh e. Resident #35 was 1 03/03/21. Review of the quarter	selected meal of the acility were cold and for the acility were cold and for the had been using Styrofoam don't hold any heat" so by the time it got delivered to ded that she had mes to the dietary manager greally improved. readmitted to the facility on led that Resident #30 was y impaired for daily decision set up assistance with herroom with her lunch tray eal plate was not served on the tray was lifted there was the plate was cool to touch. to eat her lunch that	F	804			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/07/2023 MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING _			_		C 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			2 E CENTER AVENUE OORESVILLE, NC 281	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	required set up assist An observation and ir with Resident #35 on Resident #35 was in H in front of him. He had of the meal tray and s cold, and the rice was all he was going to ea a lot of times the food cold he would eat a fe snacks that he had at the day. An observation of the conducted on 01/26/2 tray was requested. T fried rice, chicken frie roll. The test tray was tray cart and left the k PM. Once all the trays passed to the resident with the interim DM of observation revealed had no hot plate and and the plate was coo visible steam to the fo the scoop shape as it the kitchen. The shrin the chicken fried rice rice was mushy and a carrots were very cold adding salt and peppet them. The interim DM was it	laily decision making and ance with eating. terview were conducted 01/26/23 at 1:10 PM. his room with his lunch tray d eaten approximately 50% tated that the food was a mushy, and he had eaten at. Resident #35 stated that was cold and when it was ew bites then snack on some bedside to get him through lunch tray line was 3 at 11:28 AM and a test he menu included shrimp d rice, carrots, and an egg plated and placed on the titchen on 01/26/23 at 12:22 s on the unit had been ts the test tray was sampled in 01/26/23 at 12:45. The the following: the meal plate when the lid was removed, of to touch and there was no bod. The food remained in has been when plated in np fried rice was cold, and was a little warmer, but the appeared overcooked. The d and had no flavor despite er to them prior to tasting	F	04				
	had no hot plate and and the plate was coordinate visible steam to the for the scoop shape as it the kitchen. The shrin the chicken fried rice rice was mushy and a carrots were very color adding salt and pepper them. The interim DM was in 1:00 PM and confirmed	when the lid was removed, of to touch and there was no ood. The food remained in has been when plated in hp fried rice was cold, and was a little warmer, but the appeared overcooked. The d and had no flavor despite er to them prior to tasting						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/07/2023 M APPROVED O. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345179	B. WING			/08/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE		
04015		ATEMENT OF DEFICIENCIES		MOORESVILLE, NC 28115 PROVIDER'S PLAN O		(15)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 804	seasoning but added The interim DM states plates to help keep the ordered them and we needed to use them to DM further stated that tray carts and they co clear trash bags to he really did not do a go facility was trying to go insulated tray carts and and insulated tray carts and and insulated tray carts resident food hot. The Administrator was 3:00 PM who stated to facility for three week identified big issues a and he was working to just not had enough to stated that the facility	e 88 by cooked the carrots with no salt and pepper to the tray. d that the facility had no hot he food warm, but they had are waiting for equipment o be installed. The interim t they did not have insulated overed the tray carts with help hold the heat in but that od job. She stated that the yet approval to order the nd hoped that the hot plates rts would help keep the s interviewed on 01/26/23 at hat he had only been at the s. He stated he quickly and concerns in the kitchen, o correct them, but he had ime. The Administrator had purchased the plate to have the warmer installed	F 804	1		
F 805 SS=K	by a licensed electric on securing that and purchasing new insul many complaints of c	ian and they were working they were exploring ated carts to help with the old food. t Individual Needs	F 80	5		3/10/23
		es and the facility provides- repared in a form designed				
	This REQUIREMENT	is not met as evidenced iews, resident and staff		Resident #1, Resident #2	22, Resident #53,	

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APP OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345179	B. WING		C 02/08/20	23
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP	CODE	
		0.41.1.5	752 E CENTER AVENUE			
ACCORDI	US HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COME THE APPROPRIATE D	(X5) PLETIO DATE
F 805	Continued From page	e 89	F 80	15		
	interviews, the facility foods as ordered by t residents. (Resident a #53, Resident #69, R Resident #8, Resider On 01/22/23 dietary s A central supply clerk (NAs) prepared and s dinner to residents or food into small pieces consistencies. The s food production and o the food processor. likelihood for resident The Immediate Jeopa when residents with o not served 3 of 3 mea consistency. The imm removed on 2/7/23 w a credible allegation of removal. The facility of at lower scope and so	v failed to provide pureed the physician for 9 of 9 #1, Resident #22, Resident Resident #31, Resident #57, nt #17, and Resident #26). staff did not arrive for work. A and three nurse aides served breakfast, lunch, and n pureed diets by chopping is and not smooth did not have skills to operate This resulted in the high ts to choke or aspirate. Ardy (IJ) began on 1/22/23 orders for a puree diet were als pureed to a smooth nediate jeopardy was then the facility implemented of immediate jeopardy will remain out of compliance everity "E" (no actual harm pardy) to ensure monitoring place are effective.		 Resident #69, Resident #3 #57, Resident #8, Resider Resident #26 were assess by the Director of Nursing changes in condition noted The current residents prese diets have the potential to dietary audit of the current prescribed pureed diets wi by 3/9/2023 by the dietary manager/designee to ensureceived pureed diets as p The Dietary Manager will b 3/9/2023 by the Administra residents receive pureed c prescribed. The dietary staff will be ed 3/9/2023 by the dietary ma to ensuring residents recei as prescribed. The dietary staff to include staff will not be allowed to education is completed. N will be required to complet 	at #17, and sed on 2/3/2023 with no d. scribed pureed be affected. A t residents ill be completed ure residents prescribed. be educated by ator to ensure diets as lucated by anager related ive pureed diets e agency dietary work until the ew hires also	
	a. Resident #53 was	admitted to the facility on		The Administrator/ Dietary	Manager will	
	9/8/22 with diagnosis protein calorie malnu	that included dementia, trition, and diabetes.		review resident with puree for 4 weeks and monthly for ensure resident continue to	or 2 months to	
	A physician's order da Resident #53 was to liquids.	ated 9/8/22 indicated receive a puree diet with thin		pureed diets a prescribed. The Administrator/ Dietary submit the findings to the 0	Manager will	
	A quarterly MDS date Resident #53 was co set-up assistance wit	gnitively intact and required		Assurance Performance Ir (QAPI) committee monthly months for review and follo	mprovement / meeting for 3	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/07/2023 MAPPROVED). 0938-0391
STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	
AND I LAN OF	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			C
		345179	B. WING				08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	IV	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 805	Continued From page	90	F	805			
	An interview with Res 1/26/23 at 5:25 PM w ordered a puree diet a such as French toast roast beef, sweet pota peaches for lunch, an casserole, and orang she could not have or was unable to eat and available to be served the puree consistency being available. b. Resident #1 was re 10/14/21 with diagnos infarction and abnorm A physician's order da Resident #1 was to re liquids. A quarterly Minimum 1/4/23 revealed Resid impaired with short- a problems and require eating. c. Resident #22 was a 5/22/21 with diagnose dementia. A physician's order da	ident #53 was conducted on hich revealed she was and was delivered items and sausage for breakfast, ato casserole, spinach and id meat loaf, squash e slices which she realized in her prescribed diet and d no other food items were d on 1/22/23 which was of y due to kitchen staff not		805	recommendations to ensure the facility continued compliance.	'S	
		d 12/21/22 revealed gnitively impaired with short- y problems and required					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE		
		345179	B. WING				C 108/2023	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE				
		-			MOORESVILLE, NC 28115	Ι		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 805	Continued From page		F	805	5			
	extensive assistance	with eating.						
		admitted to the facility on es that included esophageal a, and dementia.						
	A physician's order dated 1/4/23 indicated Resident #69 was to receive a puree diet with thin liquids.							
	A quarterly MDS date #69 was cognitively ir minimal assistance w							
		admitted to the facility on s that included Alzheimer's, and malnutrition.						
	A physician's order da Resident #31 was to nectar thickened liqui	receive a puree diet with						
	A quarterly MDS date Resident #31 was con required extensive as	gnitively impaired and						
	11/29/22 with diagnos	admitted to the facility on ses that included dementia, ad abnormal weight loss.						
		ated 11/19/22 revealed receive a Regular diet with liquids.						
		d 12/5/22 indicated dly cognitively impaired and assistance with eating.						
	g. Resident #8 was re	admitted to the facility on						

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					PLETED
		345179	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	040110	5		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	08/2023
					752 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORES	SVILLE			MOORESVILLE, NC 28115		
(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 APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG F 805	Continued From page 10/1/22 with diagnosi quadriplegia, dementi malnutrition. A physician's order da Resident #8 was to re- liquids. A quarterly MD dated #8 had short and long and required extensiv- eating. h. Resident #17 was to 8/1/22 with diagnoses gastrointestinal esoph A physician's order da Resident #17 was to liquids. A quarterly MDS date Resident #17 had sho problems and was de i. Resident #26 was a with diagnoses that in of life care. A physician's order da Resident #26 was to diet with puree meats A Significant Change	e 92 s that included functional ia, and protein calorie ated 8/31/22 indicated eceive a puree diet with thin 10/29/22 indicated Resident g-term memory problems // assistance from staff for re-admitted to the facility on s that included dementia and hageal reflux disease. ated 2/19/21 indicated receive a puree diet with thin ed 1/22/22 indicated ort- and long-term memory gendent for eating. admitted to the facility 9/7/22 include malnutrition and end ated 12/30/22 indicated receive a mechanical soft a and thin liquids. MDS dated 1/30/23 26 was cognitively intact and		805	DEFICIENCY)	ATE	
	A brief interview with Consultant was condu	the Regional Dietary ucted on 1/23/23 at 10:08					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		SURVEY PLETED	
		345179	B. WING				08/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 805	AM. She indicated sh by the facility Adminis the staff from the diet shown up to prepare facility nursing staff w meals for all residents Dietary Consultant sta contact the former Die Regional Dietary Mar the facility to assist w instructions on how to on 1/22/23 when she dietary personnel wer kitchen equipment wa used to mechanically An interview with the conducted on 1/23/23 Administrator indicate from the dietary depa work on the morning 8:45 AM when nursin supply clerk discovere delivered to the units received their breakfa been delivered beginn indicated he lived out facility later in the day 1/22/23 to ensure me residents. The Admin dietary experience an additional direction or follow the dietary mea was unable to reach t determine why staff d 1/22/23.	e was contacted on 1/22/23 strator who notified her that ary department had not food on 1/22/23 and that ere attempting to prepare is in the facility. The Regional ated she attempted to etary Manager and the mager but did not come to ith meal service or offer o prepare meals via phone gained knowledge no re present and was unaware as unable to be properly alter diets as prescribed. Administrator was at 12:30 PM. The ed he became aware staff rtment had not arrived at of 1/22/23 at approximately g staff and the central ed no meal trays had been and no residents had ust meal which should have ning at 7:30 AM. He of state but arrived at the at approximately 2-3 PM on	F	805				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/07/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING					C 08/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
	US HEALTH AT MOORES			7	252 E CENTER AVENUE			
ACCORDI	US REALTH AT MOORES	SVILLE		N	MOORESVILLE, NC 2811	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 805	Continued From page Supply clerk indicated	94 I he was working in the	F	805				
	-	a medication aide when he ff discovered the meal trays						
	for the breakfast mea	I had not arrived at the floor						
	Supply Clerk indicate	ind 8:45 AM. The Central d they were able to locate						
		n had been printed the day /hat foods would need to be						
		l Supply clerk explained						
	since he and NA #11							
		evious employment, they						
		dge and walk-in-freezer and						
	••••	ney recalled were normally ts for the breakfast meal and						
		to cook. He stated the						
	following items were							
	omelets, sausage pat	• •						
		French toast sticks. The						
		ndicated they were unable						
	-	chine that day and instead						
	-	s in very small pieces and						
		a potato masher to serve to cally altered diets such as						
	chopped or ground m	•						
		described them to be more						
		nd consistency. The Central						
		xplained no one else from						
	the dietary departmer	nt arrived to assist with meal						
		3 and therefore, he and NA						
		ls for residents on that day.						
		erk verified that Dietary Aide						
		duled time of 10:30 AM;						
	and did not assist with	hed dishes during his shift						
		Supply clerk stated they						
		the following: lunch - roast						
		sserole, spinach, peaches,						
	and cornbread and fo							
	meatloaf, mashed pot	atoes, squash casserole,						

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		ID HUMAN SERVICES MEDICAID SERVICES				_	FORM	: 03/07/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		STRUCTION	((X3) DATE S COMPL	LETED
		345179	B. WING				C 02/0) 08/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREE	TADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E C	CENTER AVENUE			
				MOOF	RESVILLE, NC 28115			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 805	Supply clerk stated the thawing to serve on M selected that item be- accessible for lunch, consistency as close possible. An interview with NA revealed he worked of notified the dietary de the facility to prepare #11 stated they were equipment and theref properly prepare the consistency and theref properly prepare the consistency and theref small as possible and potato masher before resident on prescribe described the consist chopped. NA #11 ack follow a menu on 1/2 the walk-in-fridge and items that were acces prepared the followin breakfast were: scrar oatmeal, grits, Frenck lunch: roast beef, swe spinach, peaches, and they served: meatloa casserole, mandarin Multiple attempts wer Aide #2 were unsucc	nd a biscuit. The Central ne roast beef had been Monday and therefore he cause it was readily and they made the to chopped and ground as #11 on 1/25/23 at 10:45 AM on 1/22/23 when he was epartment had not arrived at meals to the residents. NA not able to use the kitchen fore they were unable to texture for the puree efore cut the items up as a then mashed them with a e serving the item to the d puree diets. NA #11 tency of the meats to be snowledged they did not 2/23; they strictly looked in a walk-in-freezer to find ssible and verified they g items for residents for nbled eggs, omelets, n toast, and sausage; for eet potato casserole, id cornbread and for supper f, mashed potatoes, squash oranges, and a biscuit. The made to contact Dietary essful. #10 on 1/24/23 at 1:59 PM on 1/22/23 and she was	F	805				
	revealed she worked asked to help plate a							

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CONSTRUCTION	OMB NO. 0938-0391	
	(X3) DATE SURVEY COMPLETED	
	C 02/08/2023	
REET ADDRESS, CITY, STATE, ZIP CODE		
E CENTER AVENUE		
OORESVILLE, NC 28115		
ר גו	EET ADDRESS, CITY, STATE, ZIP CODE E CENTER AVENUE ORESVILLE, NC 28115 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	C. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345179	B. WING			0	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)			(X5) COMPLETION DATE
F 805	they served: meatload casserole, mandarin of #5 indicated most foo ground consistency. An interview with the conducted on 1/26/23 she had been notified the wrong texture diel a puree diet but had r adverse effects from 1 1/22/23 nor did she ku residents did not rece A follow-up interview 1/26/23 at 3:00 PM re aware the staff were to equipment which rest ensure the proper tex residents with a mech and indicated staff sh administration aware those residents order The Administrator wa Jeopardy on 2/3/23 a The facility provided to allegation of compliant of 2/7/23. F805 o Identify those recipi are likely to suffer, a sa a result of the noncom	d cornbread and for supper f, mashed potatoes, squash oranges, and a biscuit. NA d items served were of a Medical Director was a 1:00 PM which revealed of the residents receiving t when they were prescribed not been made aware of any not receiving a puree diet on now full details of why eive the correct consistency. with the Administrator on evealed he was not made unable to use the kitchen ulted in being unable to tures were provided to nanically altered consistency ould have made before delivering meals to ed a puree diet for safety. s notified of the Immediate t 9:14 AM. the following credible nee with a compliance date	F	80	5		

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			95	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 805	texture on 1/22/2023 dietary staff were una equipment needed to items which required On 2/3/23, the current diets were reviewed b and Assistant Director changes of condition preparation and the w restrictions for the pur noted. On 2/3/2023, the Nurs aware. The current residents as a result of this define o Specify the action the process or system fail adverse outcome from when the action will b Starting 2/3/23, All fac call the Administrator immediately if dietary prepare meals to ensu- include dietary staff the contract staff, and die facilities can be called serve the prescribed of by 2/6/2023. Starting 2/3/23, the di- by the dietary manage use of the kitchen equ	for 3 of 3 meals when non ble to utilize the kitchen provide residents menu puree textures. It facility residents on puree by the Director of Nursing r of Nursing to identify any related to unsafe food vide range of dietary reed diets with no concerns se Practitioner was made on puree diets are at risk cient practice. The entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete cility staff will be educated to and the Dietary Manager staff is not available to ure trained dietary staff to nat are scheduled off, dietary tary staff from other sister d in to prepare, cook, and diets to include pureed diets etary staff will be educated er in food preparation and upment to puree prescribed nts received the prescribed	F	805			

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345179	B. WING				C 108/2023
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 805	Continued From page	99	F	80	5		
	by the Dietary Manag prepare and serve for	ietary staff will be educated er to ensure staff that od are competent in of diets including puree					
	the Administrator or d trained staff in safe fo	cility staff will be educated by designee related to only bod service preparation are bok, and serve resident clude pureed diets by					
	staff to include the die beginning of each shi receives the educatio	f, dietary and new hire will					
	Dietary Manager will u and monthly staffing s report to ensure that t adequately staffed. O and the Dietary Mana	e Administrator and the review the dietary weekly schedules during morning the dietary department is on Fridays, the Administrator oger will review the weekend eekend staffing concerns t.					
	-	ary Manager will be inistrator related to ensuring is notified of any dietary					
	Starting 2/6/2023, the Nursing/designee will residents' meal trays						

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM	APPROVED 0. 0938-0391			
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 805 F 809 SS=E	dinner to ensure that is receive their prescribes 12 weeks. Effective 2/3/2023 the responsible to ensure immediate jeopardy re non-compliance. Alleged Date of IJ Ref On 2/8/23 the credible with a completion date through staff interview training records. Staff demonstrate example serve meals, how to u 3-in-1 sink chemical to read meal tickets to e the correct consistence identify symptoms of a potential risk of a resist texture of food for corr to verbalize they were dietary department sta building by the start of Administrator and the include weekends. Frequency of Meals/S CFR(s): 483.60(f)(1)-(0 §483.60(f) Frequency §483.60(f) The score a regular times compara	for breakfast, lunch, and the residents continue to ed pureed diets for at least e Administrator will be implementation of this emoval for this alleged moval: 2/07/2023 e allegation of IJ removal e of 2/7/23 was validated v and review of in-service were able to verbalize and use the dish machine and est strips, how to properly nsure residents received ey of diet as ordered, able to a foodborne illness and dent receiving the incorrect nsumption. Each were able e to report anytime the aff were not present in the f day shift to the Director of Nursing to chacks at Bedtime (3)		805			3/10/23
	regular times compara the community or in a	able to normal mealtimes in					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345179	B. WING				C / 08/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
400000				7	752 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORES	SVILLE		N	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 809	Continued From page 101		F	809			
	hours between a subs breakfast the following nourishing snack is se hours may elapse bet	erved at bedtime, up to 16 ween a substantial evening e following day if a resident					
	meals and snacks mu who want to eat at no of scheduled meal se the resident plan of ca	e, nourishing alternative ist be provided to residents n-traditional times or outside rvice times, consistent with are. i is not met as evidenced					
	interviews, the facility when requested for 5 resident council (Resi	: ased on observations, resident and staff erviews, the facility failed to provide snacks ien requested for 5 of 5 residents reviewed for sident council (Resident #9, Resident #12, sident #27, Resident #30, and Resident #35).			Resident #9, Resident #12, Resident Resident #30, and Resident #35 are b provided snacks when requested. The current residents have the potent be affected. The nutrition rooms were	being ial to	
	200/400 hall nurses' s	: nutrition rooms on the station on 1/23/23 at 10:30 ere no snacks available for			checked on 2/1/2023 by the Administr Director of Nursing to ensure that sna were available for the residents when requested. The Dietary Manager will be educated 3/9/2023 by the Administrator to ensu snacks are available for the residents	rator/ cks I by re	
	09/13/22. Review of the quarter dated 11/11/22 reveal cognitively intact for d required set up assist	dmitted to the facility on ly Minimum Data Set (MDS) ed that Resident #9 was laily decision making and ance with eating. readmitted to the facility on			the nutrition rooms. The dietary staff will be educated by 3/9/2023 by the dietary manager relat to ensuring the nutrition rooms are be stocked to ensure snacks are availab the residents. The dietary staff to include agency die staff will not be allowed to work until the education is completed. New hires als will be required to complete the educat	ed ing e for etary ne so	

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	RM APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345179	B. WING		o	C 2/08/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE		752 E CENTER AVENUE		
ACCORD		JVILLE		MOORESVILLE, NC 28115		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 809	Continued From page	9 102	F 8	09		
	dated 12/22/22 revea cognitively intact for o required set up assist c. Resident #27 was a 08/21/13.	admitted to the facility on		The Administrator/ Dietary Man check the nutrition room 3x wee weeks to ensure residents cont have snacks available when red and nutrition rooms remain stoc snacks.	ekly for 12 inue to quested cked with ager will	
	dated 11/08/22 revea cognitively intact for c required set up assist	ly Minimum Data Set (MDS) led that Resident #27 was laily decision making and ance with eating. readmitted to the facility on		submit the findings to the Quali Assurance Performance Improv (QAPI) committee monthly mee months for review to ensure the continued compliance.	vement eting for 3	
	dated 11/03/22 revea moderately cognitivel	ly Minimum Data Set (MDS) led that Resident #30 was y impaired for daily decision set up assistance with				
	e. Resident #35 was 03/03/21.	readmitted to the facility on				
	dated 11/11/22 reveal	ly Minimum Data Set (MDS) led that Resident #35 was laily decision making and ance with eating.				
	Resident Council on residents voiced cond being available after t reported sometimes r and other times, the of send a tray with a few	with 5 residents during 1/25/23 at 3:00 PM revealed cerns about snacks not the supper meal. Residents to snacks were available dietary department would y graham crackers and boccasionally a sandwich on				

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345179	B. WING			C 02/08/2023	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ЗE	(X5) COMPLETION DATE
F 809 F 812 SS=F	the bottom of the sup each resident voiced snack at that time the the kitchen and no ot later in the night if the #9, Resident #12, and had given up asking b nursing staff (Nurse A not have snacks avail An interview with the at 3:30 PM revealed t a concern in the facili available if a resident additional food after th collected in the evenin An interview with the (ADON) on 1/26/23 a aware that snacks ha from residents, and h resolution for this com he expected snacks the residents and the faci additional funds to put hand. Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for	per meal carts; however, if they did not ask for a on the tray was returned to her snacks were available by became hungry. Resident d Resident #30 stated they because they were told by vides and Nurses) they did lable. Activity Director on 1/25/23 the lack of snacks had been ty and they were not requested to have he supper trays were ng. Assistant Director of Nursing t 11:23 AM revealed he was d been an ongoing concern e had been working to find a icern. The ADON indicated o be always available for lifty was working to use irchase snack to keep on tore/Prepare/Serve-Sanitary 2) ty requirements.		809			3/10/23

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/07/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345179	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE	
Accordi				MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLETIO
F 812	Continued From pag	e 10/	F 8 ²	12	
1 012			ГО	12	
		es not prohibit or prevent			
		produce grown in facility compliance with applicable			
		od-handling practices.			
		es not preclude residents			
		is not procured by the facility.			
	5	, , , ,			
	§483.60(i)(2) - Store,	, prepare, distribute and			
	serve food in accorda	ance with professional			
	standards for food se	ervice safety.			
	This REQUIREMEN	T is not met as evidenced			
	by:				
		ons, record review, staff		The testing equipment	
		facturer's recommendations,		2/3/2023 by the dietary	5
	the facility failed to fo	r the sanitary operation of a		measure the chemical of	
		h machine. The facility also		the dish machine and th Expired food items and	
	- ·	equipment to measure the		stored in the reach in re	
		on of the dish machine and		refrigerator, and the free	•
		centration of the 3-in 1 sink		discarded on 1/2/2023 b	
		ility also failed to remove		manager.	· · · · · · · · · · · · · · · · · · ·
	-	tored for use and date		The current residents ha	ave the potential to
		for use in 1 of 1 reach-in		be affected. The dietar	
		alk-in refrigerator and 1 of 1		completed an audit on 3	3/2/2023 to ensure
		tices had the potential to		expired food have been	
	affect all residents.			the reach in and walk in	refrigerator and
				the freezer.	
	Findings included:			The Dietary Manager w	
	1 A Health Danartm	ent document titled. Pequeet		3/9/2023 by the Adminis ensuring expired foods	
	-	ent document titled, Request investigation report" dated		from the reach in and w	
		llowing a water pipe break		and the freezer as well	•
	on 12/24/22, the loca			equipment is available t	-
		and discovered the hot		chemical concentration	
		chine could only reach 154		machine and the 3-in 1	
		The hot water required for		The dietary staff will be	
	-	I rinse to dispense water at		3/9/2023 by the dietary	-
	180 degrees Fahrenl	heit so food contact surfaces		to ensuring expired food	-
	could be sanitized ab	oove 161 degrees		discards from the reach	in and walk in

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
			5.11/10			С		
		345179	B. WING		·	02/08/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE			
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 281 ⁴	15			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETIO DATE		
F 812	Continued From page	e 105	F 81	2				
	-	ment indicated the machine		refrigerators and the	e freezer as well as			
		ed for repair and could only		-	available to measure			
		food contact surfaces and		the chemical concer	ntration of the dish			
		be transferred to the 3-in-1		machine and the 3-i				
	sink to be sanitized and a follow-up would be	-		-	nclude agency dietary			
	performed the followi	ng week.			wed to work until the			
	An observation and i	nterview with the Health		education is comple	omplete the education.			
		r and the Regional Dietary						
		at 11:28 AM revealed the		The Administrator/	Dietary Manager will			
	-	read as follows: 170			eekly for 12 weeks to			
c c	-	or the wash cycle and 185		ensure that expired	-			
	-	on the final rinse cycle.		discards from the re				
	-	partment inspector request		refrigerators and the				
	on a previous visit to	which were recommended		the chemical concer	available to measure			
	· ·	g the required temperature		machine and the 3-i				
		he final rinse cycle, the						
		nager was unable to provide						
	these to the inspecto	r or the surveyor. The Health		The Administrator/	Dietary Manager will			
	-	ed the Regional Dietary		submit the findings f	-			
		se of chlorine test strips to		Assurance Performa				
		concentration being used in			nonthly meeting for 3			
		chemical sanitation and the ny of these available on		months for review a	o ensure the facility's			
		cation during usage. The		continued compliand	-			
		ispector discussed the use						
	of the 3-in-1 sink with	the Regional Dietary						
		gional Dietary Manager was						
		ledge of the correct use of						
		d she would ensure that her						
	-	of how to use it. The Health r indicated the dish machine						
		perature of 150 degrees						
		e and the hot temperature						
	must reach a minimu							
		dishes were sanitized						
	properly.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 812	An observation and ir on 1/23/23 at 9:26 AM using the dish machin miscellaneous dishes observation revealed machine to register 14 during the wash cycle Fahrenheit during the rack exited the machi of the table to dry. Th sticker next to the gau final rinse temperature Fahrenheit. On drying machine, a rack of bo with dried food materi ready for use. Dietary not checked temperat machine on 1/23/23 a washed the rack of bo area where items wer agreed they were not An observation on 1/2 Dietary Aide #1 using and sanitize breakfas metal cooking dishes temperature gauges r Fahrenheit during the degrees on the final ri An interview with the who was serving as th Manager on 1/24/23 a aware there had beer dish machine not meet temperature of 185 de final rinse cycle and the	A revealed Dietary Aide #1 A revealed Dietary Aide #1 be to run a rack of a off the metal table. The the gauges on the dish 48 degrees Fahrenheit a and 174 degrees final rinse cycle. After the ne, it remained on the end e machine had a visible uges which indicated the e must reach 185 degrees g racks adjacent to the dish wils was sitting faced down ial and white spots on them V Aide #1 indicated she had tures before use of the dish and was not sure who had bwls, but they were in the re stored ready for use, but clean. 24/23 at 9:28 AM revealed the dish machine to clean t dishes. A large rack of was loaded, and the measured 158 degrees s washing cycle and 180 inse cycle. Regional Dietary Manager he facility Interim Dietary at 2:30 PM revealed she was n some problems with the	F	312			

Facility ID: 922988

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/07/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345179	B. WING _				C 02/08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STA	TE, ZIP CODE		
	US HEALTH AT MOORES	2V/IIIE		75	2 E CENTER AVENUE			
ACCORDI	US HEALTH AT MOORES	JVILLE		M	OORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	• 107	F 8	12				
	1/24/23 at 2:30 PM recookware in the 3-in-7 had not been taught f testing strips for the 3 chemical testing for co- checked in the mornin and stated she had no using the sink during f had added chemicals attached to the chemi During this observation test strips available. An observation on 1/2 Cook #2 place cookin slide them into the dis The gauges on the dis The gauges on the dis 170 degrees Fahrenh and 170 degrees Fah cycle. A follow-up visit docum Department dated 1/2 Inspector met with the notified her the dish m to provide hot water a during the final rinse. water temperature rea Fahrenheit and per te chlorine concentration however, the facility h	ng by other staff members bet ever tested them while any of her shifts. Cook #3 to the sink through a hose cals which were premixed. on there were no chemical 25/23 at 11:27 AM revealed g utensils on a rack and sh machine and walk away. sh machine at the time read: eit during the wash cycle renheit during the final rinse ment from the Health 26/23 indicated the Health 26/23 indicated the Health a interim Administrator who hachine had been modified and chemical sanitation During this visit the hot ached 182 degrees st from the inspector the measured 100 ppm;						
	log of dish machine te provide chlorine testir	that the facility maintain a emperatures as well as ig supplies to ensure the of chlorine was used for						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/07/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE	
		245470					С
		345179	B. WING			02/	08/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE		
				Ν	MOORESVILLE, NC 28115		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 108	F	812	2		
	sanitation of the dishe	es in the dish machine.					
	1/23/23 beginning at 10:05 AM with Dietar	egional Dietary Consultant.					
	In the reach in fridge:						
	unlabeled or dated wi	unsealed bag of parsley ith visible spoilage on the wn leaves and a slimy film leaves					
	-A partially used head dated	d of lettuce unlabeled or					
	-A plastic gallon sized bologna with a used b	d resealable plastic bag with by date of 1/19/23.					
	-4 ½ sized peanut but open to air and the br	tter sandwiches with baggies read was hardened.					
	-A partially used contause by 1/18/23	ainer of chicken salad with a					
	-A partially used box had a use by date of	of pasteurized eggs which 12/23/22.					
	In the dry storage:						
	A rack containing two or date.	bags of buns with no label					
	In the walk-in freezer	:					
		of Italian sausage links d which showed visible frost					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/07/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE		7	752 E CENTER AVENUE		
ACCORD				Ν	MOORESVILLE, NC 28115		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 812	Continued From page	e 109	F	812			
	and ice on the surface	e of the link					
		of sliced carrots with a ble on the surface unlabeled d					
	-A partially used bag unlabeled or dated	of 14 cubed beef steaks					
	-A partially used bag toast sticks unlabeled	of approximately 30 French I or dated					
	-A partially used bag unlabeled or dated	of 4 breaded chicken patties					
	-A partially used bag unlabeled or dated	of 8 hamburger patties					
	In the walk-in fridge:						
		ng stem onions with visible I slimy greenage labeled					
	-1/2 a pound cake in dated.	a zip lock bag unlabeled or					
	-2 large bags contain visible brown spoilage	ing heads of lettuce with e on the leaves.					
	-A metal container wir unlabeled or dated	th chicken noodle soup					
	on 1/23/23 at 10:00 A building on this morni with the current Dieta the reason why many	Regional Dietary Consultant M revealed she was in the ing due to an emergency ry Manager and indicated r items were left unlabeled or past the expiration date was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345179	B. WING		C 02/08/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORD	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 812 F 814	due to a lack of staff Dietary Manager india had been trained to la they are opened and when they are showin reached their expirati stated these items lis been readily available	on 1/22/23. The Regional cated all dietary personnel abel and date all items when to discard all food items ng signs of spoilage or on date or use by date. She ted above should not have e for usage by staff.	F 81		3/10/23
SS=F	 §483.60(i)(4)- Dispos properly. This REQUIREMENT by: Based on observation facility failed to ensurd dumpster was free of contained in an enclo dumpsters reviewed. The finding included: An observation of the at 10:06 AM was made Regional Dietary Con- revealed two dumpster overflowing bags of the was overflowing with ground around the du approximately 25 bag used briefs. There we boxes piled approxim- been dampened by a debris consisted of si briefs, plastic bottles, adjacent to the dump 	ers that contained rash and 1 receptacle which cardboard. The area on the impster was littered with gs of trash which contained ere semi-flattened cardboard nately 3-4 feet tall which had recent rain. Scattered ngle use meal containers,		The debris and trash around the dumpster was cleaned up and placed the dumpster on 1/24/2023 by the Maintenance Director. The current residents have the potent be affected. The Maintenance Staff, the housekee Manager and the dietary manager wi educated by 3/9/2023 by the Administ related to ensuring the dumpster is cle and no debris and trash is around the dumpster area. The housekeeping and dietary staff w educated by the Maintenance Directo Administrator related to ensuring the dumpster is closed and no debris and trash is around the dumpster area. The Maintenance staff, housekeeping and dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education.	ial to ping II be trator osed ill be r/

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TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	IO. 0938-039 E SURVEY PLETED	
	OUNTEDHON	IDENTIFICATION NOWIDER.	A. BUILDING	G			C	
		345179	B. WING			0	2/08/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 814	Continued From page	e 111	F 81	4				
	drainage potential.				The Administrator will check the dump area weekly for 12 weeks to ensure the			
	1/23/23 at 10:08 AM	ducted with the RCD on which revealed she thought			dumpster is closed and no debris and trash is around the dumpster area.			
	the dumpsters were of weekly. The RDC wa areas were left in the stated these condition risk for pest, rodents in the area.			The Administrator will submit the findi to the Quality Assurance Performance Improvement (QAPI) committee mont meeting for 3 months for review and follow up with recommendations to er the facility's continued compliance.	e hly			
	AM revealed the dum weekly on Tuesdays indicated he was uns collected this amount dumpsters were emp acknowledged the co	ok #2 on 1/23/23 at 10:10 apsters were emptied twice and Fridays. Cook #2 ure why the dumpsters had of disposal since the tied on Friday 1/17/23. He inditions could potentially s, rodents, and local wildlife						
	1/24/23 at 3:15 PM re dumpster areas were on 1/23/23 until he we day. The Maintenance intentions to contact to but had not yet been a 3 times per week per overflow of receptacle would increase the per rodents in the facility.	es and acknowledged it otential for hosting pest and He further explained it rt of all staff to ensure the						
	3:00 PM revealed he dumpsters were over							

			A 450 A 47 47 5		0.000		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE		
		345179	B. WING		C 02/08/2		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	100/2020	
ACCORDI	US HEALTH AT MOORE	SVILLE		752 E CENTER AVENUE MOORESVILLE, NC 28115			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 814	and should be every	e 112 one's responsibility to pick-up en the dispose of trash in the	F 81	4			
F 835 SS=K	Administration CFR(s): 483.70		F 83	5		3/10/23	
	enables it to use its r efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on record rev interviews, the facility provide effective lead ensure effective lead ensure effective syste trained dietary staff a residents. On 1/22/23 to work and the Cent Nurse Aides (NAs) pr and dinner resident r residents mechanica (Resident #1, Resider Resident #69, Resider This led to the high li choking.	ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced iew, resident, staff γ Administration failed to dership and oversight to ems were in place to have available to prepare meals for 3 dietary staff did not arrive ral Supply Clerk and three repared breakfast, lunch, meals without serving 9 of 9 Ily altered meals as ordered ent #22, Resident #53, ent #31, Resident #57, nt #17, and Resident #26). kelihood of aspiration or		Resident #1, Resident #22, Residen Resident #69, Resident #31, Resider #57, Resident #8, Resident #17, and Resident #2 were assessed by the licensed nurses on 2/3/2023 with no and symptoms of aspiration/choking noted. The current residents with mechanica altered meals have the potential to be affected. An audits will be completed 3/9/2023 of the residents with mechanically altered meals by the Director of Nursing/ designee. The Dietary Manager will be educate	it signs ally e l by d by		
	when systems were in dietary staff were available. The immediat 2/7/23 when the facil allegation of immediat facility will remain ou	ardy (IJ) began on 1/22/23 not in place to ensure trained ailable to prepare resident re jeopardy was removed on ity implemented a credible ate jeopardy removal. The t of compliance at lower E" (no actual harm that is		3/9/2023 by the Administrator to ensure residents receive mechanically altered diets as prescribed and the Administr is notified of any dietary staffing conc The dietary staff and the nursing staff be educated by 3/9/2023 by the dietar manager related to ensuring resident	d ator erns. [:] will ry		

Facility ID: 922988

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,	
		345179	B. WING		C 02/08/2023		
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	CODE		
				752 E CENTER AVENUE			
ACCORDI	US HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE COMPL D THE APPROPRIATE DA	ETIO	
F 835	Continued From page	e 113	F 83	5			
	immediate jeopardy) systems are put into	to ensure monitoring		receive the mechanically prescribed.			
	Findings included: Cross Refer to F802			The dietary and the nursi educated by 3/9/2023 rel the Administrator and/or 1	ated to notifying the Dietary		
	facility failed to have	ews and record reviews, the effective systems in place to etary staff to prepare meals		manager if there are cond staff. They will also be ma Administrator and the Die	ade aware the		
	when dietary staff did	I not arrive to work on the Supply Clerk and three		information is posted at e station and in the kitchen	ach nursing		
	and dinner resident m	epared breakfast, lunch, neals without checking the of cooked foods before		The dietary staff and the include agency staff will r	-		
	serving, did not serve	e resident mechanically ed, and did not ensure		work until the education is New hires also will be rec	s completed.		
	likelihood for resident	anitized. This led to the high is to be at risk of choking or		complete the education.			
	aspiration. This situat residents for 3 of 3 m			The Administrator will rev staff daily in morning repo addition on Fridays the w	ort and in		
	Cross Refer to F805			will be reviewed to ensure	e dietary staffing		
		ews, resident and staff r failed to provide pureed		concerns are addressed. manager will call the Adm	2		
	foods as ordered by t residents. (Resident a	he physician for 9 of 9 #1, Resident #22, Resident esident #31, Resident #57,		staff callout to ensure the to have adequate dietary	facility continues		
	Resident #8, Resider On 01/22/23 dietary s	nt #17, and Resident #26). staff did not arrive for work.		The Administrator and the Manager contact informa	tion will be		
	(NAs) prepared and s	and three nurse aides served breakfast, lunch, and		posted at the nursing stat kitchen to ensure that if s	taff notice dietary		
	food into small pieces	n pureed diets by chopping s and not smooth taff had not been trained on		staffing concerns they ca Administrator and/or the			
	food production and o	did not have skills to operate Fhis resulted in the high		The Administrator/ Dietar review 10 residents with			
	likelihood for resident	s to choke or aspirate.		altered diets weekly for 4 monthly for 2 months to e	weeks and ensure residents		
	The Administrator wa Jeopardy on 2/3/23 a	s notified of the Immediate t 9:14 AM.		continue to be served me altered diets a prescribed	-		

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/07/2023 MAPPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		345179	B. WING		C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO			
	US HEALTH AT MOORE	ev/II I E		752 E CENTER AVENUE			
ACCORD	US REALTH AT MOURE	SVILLE		MOORESVILLE, NC 28115			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	Continued From page 114		F 83	35			
	of 2/7/23. The Administration fa acceptable plan was kitchen emergency of On, 1/22/2023 at abo identified that there w kitchen to prepare bro was notified immedia Administrator notified 9:00 am. The Adminis notify the dietary mar was unable to reach regional support was about 9:15am who w manager. Later that was made aware that unable to be reached emergency by the die Facility leadership sta Director of Nursing (<i>A</i> Maintenance and the called on 1/22/2023 the 9:20 am and began of with resident meals a facility leadership atte from an outside vend building about 9:35 a arrived at the facility f lunch. On 1/22/2023, the Acc Dietary Facility Regio	nce with a compliance date iled to ensure that an implemented during the		The Administrator/ Dietary M submit the findings to the Q Assurance Performance Im (QAPI) committee monthly of months for review and follow recommendations to ensure continued compliance.	provement meeting for 3 w up with		

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	-	ID HUMAN SERVICES				FORM	M APPROVED
STATEMENT O	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			PLETED
		345179	B. WING				C 108/2023
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	00,2020
ACCORDI	US HEALTH AT MOORES	SVILLE					
	SUMMADY ST	ATEMENT OF DEFICIENCIES	10		MOORESVILLE, NC 28115		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 835	Continued From page	9 115	F	835	5		
	was in the facility to p the dietary Departme	e Dietary Regional support rovide ongoing leadership in nt to ensure the safe idents' physician ordered					
	The facility residents a result of this deficie	on 1/22/2023 were at risk as nt practice.					
	process or system fai	he entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete					
	Health Group Corporation ongoing follow up to e	ne Administrator and Maple ate leadership will provide ensure that the dietary s to be staffed as required.					
	the Chief Nursing Offi preparedness plan up staffing schedule revi dietary manager and information will be pro and posted on the nu so that the facility will outs. The Administrat	ninistrator was educated by icer on the emergency odates to include the dietary ew process and that the the Administrator contact ovided to the dietary staff rsing units and in the kitchen be aware of dietary staff call or is aware that he is ing the emergency plan is					
	checklist which includ staffing, dietary staffir completion, residents dish machine at appro	e Dietary Kitchen Oversight les monitoring for dietary ng competencies ' receiving pureed diets, opriate temperature, and ill be completed by the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE		
		345179	B. WING				C 108/2023	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	H CORRECTIVE ACTION SHOULD BE C REFERENCED TO THE APPROPRIATE		
F 835	facility interdisciplinary team Assistant Director of I maintenance, Busine clerk, and activities w oversight checklist by On 2/6/2023, the facil Preparedness Plan u the Quality Improvem Administrator to inclus schedule review proc manager and the Administrator and posted on the nu so that the facility will outs. The Administrat responsible for ensur- being followed. Starting 2/6/2023, the Nursing Officer or the complete facility roun least monthly to ensu /dietary Emergency P to be followed as requ Starting 2/3/23, all cu hire dietary staff will b facility education relat receive diets as order completed, training on equipment, and notifie Dietary Management 2/6/2023 by the Regio	y team staff. The to include social services, Nursing, Medical Records, ss office, admissions, supply ere educated on the the Administrator. ity Emergency pdates will be reviewed in ent meeting by the de the dietary staffing ess and that the dietary ninistrator contact ovided to the dietary staff rsing units and in the kitchen be aware of dietary staff call or is aware that he is ing the emergency plan is e Maple Health Group Chief Chief Operation Officer will ds to include the kitchen treparedness Plan continues	F	83	35			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345179	B. WING				C 08/2023	
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 835	Continued From page	: 117	F	835				
		Administrator will be implementation of this emoval for this alleged						
F 849 SS=D	· ·		F	849			3/10/23	
	do either of the follow (i) Arrange for the pro- through an agreemen Medicare-certified hos (ii) Not arrange for the services at the facility a Medicare-certified h resident in transferrin	term care (LTC) facility may ing: vision of hospice services t with one or more spices. e provision of hospice through an agreement with ospice and assist the g to a facility that will ion of hospice services						
	LTC facility through a paragraph (o)(1)(i) of the LTC facility must n requirements: (i) Ensure that the hos professional standard to individuals providin to the timeliness of th (ii) Have a written agr that is signed by an a the hospice and an ar the LTC facility before	spice services meet s and principles that apply g services in the facility, and						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		
		345179	B. WING				C 08/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE		
					MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE		
TAG F 849	Continued From page (A) The services the f (B) The hospice's res the appropriate hospic in §418.112 (d) of this (C) The services the f provide based on eac (D) A communication communication will be LTC facility and the fac that the needs of the met 24 hours per day (E) A provision that the notifies the hospice at (1) A significant changemental, social, or emo (2) Clinical complication alter the plan of care. (3) A need to transfer for any condition. (4) The resident's dea (F) A provision statinger responsibility for deter course of hospice car determination to chan provided. (G) An agreement that responsibility to furnis care, meet the resider nursing needs in coor representative, and emotions	e 118 hospice will provide. ponsibilities for determining ce plan of care as specified a chapter. _TC facility will continue to th resident's plan of care. process, including how the e documented between the ospice provider, to ensure resident are addressed and e LTC facility immediately bout the following: ge in the resident's physical, otional status. ons that suggest a need to the resident from the facility ath. g that the hospice assumes rmining the appropriate		84	DEFICIENCY)		
	including but not limit direction and manage counseling (including bereavement); social	he hospice's responsibilities, ed to, providing medical ement of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs					

Facility ID: 922988

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345179	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 849	associated with the teconditions; and all oth necessary for the card illness and related coo (I) A provision that will personnel are respon of prescribed therapies determined appropriat delineated in the hosy facility personnel may where permitted by S the LTC facility. (J) A provision stating report all alleged viola mistreatment, neglect and physical abuse, in source, and misappro- by hospice personnel administrator immedia becomes aware of the (K) A delineation of the hospice and the LTC bereavement services §483.70(o)(3) Each L provision of hospice co- agreement must design facility's interdisciplinat for working with hospic coordinate care to the LTC facility staff and h interdisciplinary team clinical background, fu	iation of pain and symptoms rminal illness and related her hospice services that are the of the resident's terminal inditions. hen the LTC facility sible for the administration te by the hospice and bice plan of care, the LTC or administer the therapies tate law and as specified by g that the LTC facility must ations involving t, or verbal, mental, sexual, including injuries of unknown opriation of patient property t, to the hospice ately when the LTC facility te alleged violation. he responsibilities of the facility to provide to LTC facility staff. TC facility arranging for the care under a written gnate a member of the ary team who is responsible ice representatives to the resident provided by the hospice staff. The	F	849			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345179	B. WING				C 08/2023
NAME OF P	ROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 849	The designated interce responsible for the fol (i) Collaborating with and coordinating LTC the hospice care plan residents receiving th (ii) Communicating wi and other healthcare provision of care for the conditions, and other of care for the patient (iii) Ensuring that the with the hospice medi- attending physician, a participating in the pro- as needed to coordina medical care provided (iv) Obtaining the follo- hospice: (A) The most recent to each patient. (B) Hospice election (C) Physician certific- the terminal illness sp (D) Names and conta personnel involved in patient. (E) Instructions on ho 24-hour on-call syster (F) Hospice physicia any) orders specific to (v) Ensuring that the I orientation in the polio facility, including patie	lisciplinary team member is lowing: hospice representatives facility staff participation in ning process for those ese services. th hospice representatives providers participating in the he terminal illness, related conditions, to ensure quality and family. LTC facility communicates ical director, the patient's and other practitioners ovision of care to the patient ate the hospice care with the d by other physicians. owing information from the hospice plan of care specific form. ation and recertification of pecific to each patient. act information for hospice hospice care of each ow to access the hospice's m. on information specific to n and attending physician (if peach patient. LTC facility staff provides cies and procedures of the ent rights, appropriate forms, equirements, to hospice staff	F	849	9		

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	-	D HUMAN SERVICES				FORM	1 APPROVED
	<u>S FOR MEDICARE & I</u> DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		CONSTRUCTION	(X3) DATE	0.0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							c l
		345179	B. WING				08/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	US HEALTH AT MOORES	2/11 E		7	52 E CENTER AVENUE		
ACCORDI				Μ	IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 849	Continued From page	9 121	F	849			
	care under a written a each resident's written the most recent hospid description of the serv facility to attain or ma practicable physical, n well-being, as require This REQUIREMENT by: Based on record revif facility failed to ensure to initiate hospice serv reviewed for hospice. The findings included Resident #65 was add 01/26/22 with diagnos cancer and hemiplegi Review of Resident # revealed hospice care he received hospice so 03/09/22. A review of Resident # Minimum Data Set as revealed Resident #6 impaired. Resident #6	vices furnished by the LTC intain the resident's highest mental, and psychosocial d at §483.24. is not met as evidenced ew and staff interviews, the e there was an active order vices for 1 of 1 resident (Resident #65) : mitted to the facility on ses that included brain a. 65's medical record e plan documentation that services beginning on #65's most recent quarterly sessment dated 12/19/22 5 to be moderately 55 was coded as having a isease that may result in a s than 6 months. Resident as receiving hospice			Resident #65 order for hospice service was obtained on 1/26/23 by the license nurse. The current residents on hospice servi have the potential to be affected. An ar- was completed on 2/1/2023 by the licensed nurse to ensure residents receiving hospice services have a physician order. The licensed nurses to include agency licensed nurses will be education by 3/9/2023 related to ensuring they are obtaining physician orders for residents receiving hospice service. New hire licensed nurses will not be able to work until the education is completed. The Director of Nursing will review curr residents weekly for 4 weeks and mon for 2 months to ensure licensed nurses are obtaining physician orders for residents receiving hospice services.	ed ces udit s s c thly	
		#65's physician orders der admitting Resident #65			The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI)		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345179	B. WING		C 02/08/2023
NAME OF PF	OVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZI	•
		o. // . =		752 E CENTER AVENUE	
ACCORDI	JS HEALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE
F 849	Continued From page	e 122	F 84	49	
	1.0			committee monthly meet	ing for 3 months
	During an interview w	vith Nurse #3 on 01/26/23 at		for review and follow up	•
	•	ed she was aware Resident		recommendations to ens	
	#65 received hospice	e care. She stated there		continued compliance.	-
		order in Resident #65's chart			
		ent #65 was admitted to			
		ported she could not locate			
	hospice.	esident #65 to be admitted to			
	Nursing on 01/26/23	vith the Assistant Director of at 12:10 PM, he reported have an active physician			
	order showing he was	s admitted to hospice care.			
		hy Resident #65 did not			
	have an active physic admitted to hospice.	cian order showing he was			
	•	vith the Director of Nursing PM, she reported she was			
		lent #65 not having an active			
		ospice services earlier in the			
		e reported she contacted the			
		at serviced Resident #65 and			
		n date and then requested a			
		the Medical Director that			
		s admission date to hospice pany that provided the			
	-	65. She stated Resident #65			
		e physician order for hospice			
		d the error was overlooked			
	by the previous admi	nistration. The Director of			
		e expected all residents who			
	•	vices to have an active			
		ating the start date and			
	hospice company tha QAPI/QAA Improvem	at provided the service.	F 86	27	3/10/23
F 867					13/10/23

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345179	B. WING				08/2023
NAME OF P	ROVIDER OR SUPPLIER	L	I	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 123	F	867	7		
	monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu- following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be us are high risk, high vol opportunities for impr §483.75(c)(2) Facility systems to identify, cr information from all d not limited to the facil §483.70(e) and includ will be used to develor indicators. §483.75(c)(3) Facility and evaluation of per including the methods systematically identify analyze and use data adverse events in the	and monitoring, including wing. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and ves, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will y, report, track, investigate, and information relating to a facility, including how the ta to develop activities to					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345179	B. WING				08/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 page	e 124	F	867	7		
	§483.75(d) Program s systemic action.	systematic analysis and					
	aimed at performance						
	determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility w	Idressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to					
	performance improve high-risk, high-volume consider the incidenc of problems in those a	cility must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy,					
	resident events, analy implement preventive	nedical errors and adverse					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345179	B. WING				C 08/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT MOORE	SVILLE			52 E CENTER AVENUE			
				Ν	NOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page facility. §483.75(e)(3) As part		F	867				
	improvement activitie distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas collection and analysi (c) and (d) of this sec	s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs						
	governing body, or de functioning as a gove activities, including im program required unce (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under the resulting from drug re available data to mak This REQUIREMENT by: Based on observatio interviews, the facility Assurance (QAA) cor	reports to the facility's esignated person(s) rning body regarding its aplementation of the QAPI ler paragraphs (a) through e committee must: ement appropriate plans of tified quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on e improvements. ' is not met as evidenced ns, record reviews and staff 's Quality Assessment and nmittee failed to maintain			Quality Assessment and Assurance (QAA) Committee was held on 3/2/2023 by the Administrator related to ensuring	I		
	implemented procedul interventions the com				the facility has effective systems to obta information and/or feedback from facility			

Facility ID: 922988

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/07/202 M APPROVE O. 0938-039	
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345179	B. WING		C 02/08/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
	US HEALTH AT MOORE			752 E CENTER AVENUE			
ACCORD	US REALTH AT MOORE	SVILLE		MOORESVILLE, NC 28115			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 867	conducted on 06/25/2 investigation survey of the focused infection investigation surveys 12/07/20. This failure were originally cited i Comfortable and Hom Develop and Impleme Plans (656), ADL (Ac Provided for Depende Increase or Prevent D Motion) or Mobility (F Tracheostomy Care a Sufficient Dietary Sup Nutritive Value and A Preferred Temperatur Meals and Snacks at Procurement, Storage Under Sanitary Cond subsequently recited and complaint investi The repeat deficienci surveys of record sho facility's inability to su program. The findings include: This tag is cross refer F-584: Based on obs and staff interviews th exposed damaged dr hall) and affected 5 o #103, Room #107, Re Room #111), the facil personal care items la	cation and complaint survey 21, the complaint conducted on 06/15/22 and control and complaint conducted on 04/29/22 and was for 9 deficiencies that in the areas of Safe, Clean, nelike Environment (F584), ent Comprehensive Care tivities of Daily Living) Care ent Resident (F677), Decrease ROM (Range of 688), Respiratory or and Suctioning (F695), oport Personnel (802), ppearance, Palatable and re (F804), Frequency of Bedtime (F809), and Food e, Prepared and Served itions (F812) that were on the current recertification gation survey on 02/08/23. es during five federal owed a pattern of the ustain an effective QAA	F 86	 staff, residents and residents representatives to identify proopportunities for improvement. The current residents are at rithis deficient practice. The interdisciplinary team was on 3/2/2023 by the Chief Nurse related to ensuring the QAA Comaintain and implement processor obtain information and/or feed facility staff, residents and reserepresentatives to identify proopportunities for improvement. The Administrator will be respmonitoring the Quality Assura Performance Improvement PI monthly for 3 months to ensure facility remains in compliance deficiencies. The Administrator will report for the audits in the monthly Qua Assurance Performance Improvement and the audits in the monthly Qua Assurance Performance Impresentation and presentation and presentation and presentation and presentatives to ensure compliance. 	t. isk related to as educated sing Officer Committee esses to dback from sidents oblems and t. oonsible for ince an process re that the for identified indings of lity ovement months for		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345179	B. WING				C /08/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	#401/403, and Rooms During the recertificat conducted on 06/25/2 and sanitize the doorf residents' personal ca and store residents' p bathrooms (shared ba #107-109,#202-204, a ensure walls and doo scratches for 2 of 8 ba of rooms #107-109 ar also failed to ensure 2 rooms (500 hall and the rooms) were free of ca in good repair for area environment. During the focused in complaint investigatio 04/29/22 the facility 1 was in good repair in (Room #112); 2) failed environment in 4 of 3 (Room #112, #204, #2 have damaged and sp borders and doors, so	ooms #400/402, Rooms s #405/407). ion and complaint survey 21 the facility failed to clean frames, label and store are items and failed to label tersonal care items in 2 of 8 athroom of rooms and #204-#206) and failed to rs were free from holes and athrooms (shared bathroom nd #202-204). The facility 2 of 3 community shower he 200 hall male shower lutter, clean, sanitized and as reviewed for fection control and on survey conducted on) failed to ensure baseboard 1 of 6 resident bathrooms d to maintain a homelike 1 resident rooms/bathrooms 301, and #308) observed to	F	867			
	back of a room door; bathroom with a stron resident bathrooms (F resident halls (100 Ha	3) failed to clean a ig odor of urine in 1 of 6 Room #300) on 3 of 4 all, 200 Hall, and 300 Hall).					
	resident, and staff inte implement a compreh resident that wandere	ervations, record review, erview's the facility failed to ensive care plan for a ed daily (Resident #43) and balized a desire to lose					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345179	B. WING			02	C 2/08/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	04/29/22 the 1) failed by not applying a han comprehensive care p complete and individu living care plan for 2 of reviewed (Resident # F-677: Based on obso staff and resident inter provide dependent re (Resident #74, #183, to provide nail care (F provide shaves (Resident #7 provide shaves (Resident #7 provide shaves (Resident #7 provide shaves (Resident #7) and fail showers (Resident #7 #17, and Resident #4 reviewed for activities During the complaint conducted on 06/15/2 perform routine incom and failed to provide s) for 2 of 4 residents fection control and in survey conducted on to implement interventions d splint as specified in the plan and 2) failed to ualize an activity of daily of 3 sampled residents 5 and Resident #11). ervations, record reviews, erviews, the facility failed to sidents with showers #184 and #186) and failed Resident #53) and failed to dent#75) to 6 of 8 residents a of daily living. ion and complaint conducted on 06/25/21 the m routine incontinent care ed to provide scheduled 24, Resident #37, Resident 5) for 5 of 10 residents a of daily living. investigation survey 22 the facility failed to tinent care (Resident #7)	F	867	7		
	activities of daily living F-688: Based on observesident, and staff inte	f 10 residents reviewed for g. ervations, record review, erview's the facility failed to splint and palm guard as					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345179	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	·	
ACCORD	US HEALTH AT MOORES	SVILLE			52 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	ordered for 1 of 3 res reviewed for range of During the recertificat investigation survey of facility failed to assist (Resident #21) and fa of 2 (Residents #13 a positioning and mobil During the focus infect investigation survey of facility failed to apply contractures manage for 1 of 1 sampled res #5). F-695: Based on obse and staff interview's t administer oxygen at failed to clean the oxy of 3 residents reviewed (Resident #11). During the recertificat investigation survey of facility failed to admin prescribed rate for 1 of reviewed for respirato During the focus infect investigation survey of facility failed to admin prescribed rate for 1 of reviewed for oxygen to F-802: Based on staff reviews, the facility fai systems in place to e	idents motion (Resident #48). tion and complaint conducted on 06/25/21 the ambulation for 1 of 1 ailed to provide splints for 2 and #44) reviewed for ity services. tion control and complaint conducted on 04/29/22 the a hand splint for ment per physician's order sident reviewed (Resident ervations, record review, he facility failed to the prescribed rate and /gen concentrator filter for 1 ed for respiratory care tion and complaint conducted on 06/25/21 the hister oxygen at the of 1 resident (Resident #45) ory care. tion control and complaint conducted on 04/29/22 the hister oxygen as prescribed of 2 residents (Resident #3) therapy.	F	867			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345179	B. WING				C 108/2023
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MOORES	SVILLE			752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Clerk and three Nurse breakfast, lunch, and without checking the i cooked foods before a resident mechanically This led to the high lik at risk of choking or a affected 9 of 9 resider #22, Resident #53, R Resident #57, Reside Resident #26) for 3 of prepared breakfast, lu meals without checkin of cooked foods befor residents. During the focus infect investigation survey of facility failed to have a ensure the menu was dietary aide was the of reported to work and consultation from the Regional Dietary Mar sandwiches for the eval ray, resident, and sta failed to provide palat appetizing in temperat residents reviewed wi #9, Resident #12, Re and Resident #35). During the recertificat investigation survey of	1/22/23. The Central Supply e Aides (NAs) prepared dinner resident meals internal temperature of serving and did not serve y altered diets as ordered. Kelihood for residents to be aspiration. This situation ints (Resident #1, Resident esident #69, Resident #31, ent #8, Resident #17, and f 3 meals. The staff also unch, and dinner resident ing the internal temperature re serving for 91 of 91 ction control and complaint conducted on 04/29/22 the sufficient dietary staff to a followed. On 04/24/22 a only staff member that made the decision without Dietary Manager or hager to serve residents yening meal. This affected orders. ervations, record review, test aff interview's the facility table food that was iture and texture for 5 of 5 ith food concerns (Resident sident #27, Resident #30,	F	86	7		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	PLETED
		345179	B. WING				C / 08/2023
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2023
				7	752 E CENTER AVENUE		
ACCORDI	US HEALTH AT MOORES	SVILLE		N	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	appetizing in appeara for 6 of 6 residents re (Resident #09, Reside Resident #20, Reside F-809: Based on obse- interviews, the facility when requested for 5 resident council (Resi Resident #27, Reside During the recertificat investigation survey of facility failed to provid for 1 of 1 resident (Resinances) staff interviews and m recommendations, the manufacturer's recom- operation of a high te The facility also failed to measure the chem dish machine and ensichemical concentration facility also failed to re- stored for use and da use in 1 of 1 reach-in refrigerator and 1 of 1 During the recertificat investigation survey of facility failed to label a in 1 of 1 reach-in refri storage areas, and 2 refrigerators, failed to individual packets of walk-in refrigerators, failed to individual packages of	ance, taste, and temperature viewed with food concerns ent #10, Resident #15, ent #24, and Resident #40). ervations, resident and staff failed to provide snacks of 5 residents reviewed for ident #9, Resident #12, ent #30, and Resident #35). ion and complaint conducted on 06/25/21 the le snacks when requested esident #30) reviewed for ervations, record review, nanufacturer's e facility failed to follow immendations for the sanitary mperature dish machine. I to have testing equipment ical concentration of the sure staff tested the on of the 3-in 1 sink. The emove expired food items te leftover foods stored for refrigerator, 1 of 1 walk-in freezer. tion and complaint conducted on 06/25/21 the and date opened food items gerators, 1 of 1 dry goods of 2 nourishment room remove a case of expired sour cream from 1 of 1 and failed to store four, of ground beef in a way that	F	867			
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR I REGULATORY OR I Continued From page appetizing in appeara for 6 of 6 residents re (Resident #09, Reside Resident #20, Reside F-809: Based on obse interviews, the facility when requested for 5 resident council (Resi Resident #27, Reside During the recertificat investigation survey of facility failed to provid for 1 of 1 resident (Resi snacks. F-812: Based on obse staff interviews and m recommendations, the manufacturer's recom operation of a high te The facility also failed to re stored for use and da use in 1 of 1 reach-in refrigerator and 1 of 1 During the recertificat investigation survey of facility failed to label a in 1 of 1 reach-in refri storage areas, and 2 refrigerators, failed to individual packets of walk-in refrigerators, failed to individual packages of	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMF

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 03/07/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345179	B. WING		_	C 02/08/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE	01	
ACCORDIUS HEALTH AT MOORESVILLE			752 E CENTER AVENUE				
			MOORESVILLE, NC 28115				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 867	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 86				

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