DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPR	OVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-	-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		345304	B. WING		C 02/23/2023	3
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5
ACCORDI	US HEALTH AT MIDWOO	DD, LLC		2727 SHAMROCK DRIVE		
		,		CHARLOTTE, NC 28205		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE	ETION
F 000	INITIAL COMMENTS		F 00	0		
	from 02/20/23 throug returned to the facility credible allegations o exit date was change #7H7J11. The followi NC00196327, NC001 of the seven allegation deficiency. Intake NC immediate jeopardy. Immediate Jeopardy CFR 483.25 at tag 68 (J) PNC- Past Nonco CFR 483.25 at tag 68 (J) PNC-Past Noncor	was identified at: 14 at a scope and severity mpliance 19 at a scope and severity				
F 684 SS=J		began on 02/04/23 and was . A partial extended survey	F 684	4		
	applies to all treatment facility residents. Base assessment of a residents received accordance with profession	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE	
Electroni	cally Signed				03/09/2	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.

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIE	PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		G	· · /	MPLETED
						С
		345304	B. WING			2/23/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
ACCORDI	US HEALTH AT MIDWOO	DD, LLC		2727 SHAMROCK DRIVE		
				CHARLOTTE, NC 28205		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 684	Continued From page	e 1	F 68	34		
		is not met as evidenced				
	by:					
		iew and resident, staff, and		Past noncompliance: no plar	n of	
		the facility failed to ensure essed following a fall from		correction required.		
		facility van on 2/4/23. The				
		lid not report the accident to				
		g until the evening of 2/5/23.				
	Nursing staff were no					
		e no assessment was				
		e Practitioner was contacted ht #1's complaint of right leg				
		ays of the resident's right hip				
		e negative for fractures or				
	dislocations. When R	esident #1 was informed of				
		s, she requested to be sent				
		om for evaluation on 2/6/23				
	due to increased pair	nbar spinal tenderness upon				
		computer tomography (CT)				
		erate spinal canal stenosis				
		egion of the spine) with				
	possible right parace					
		spinal disc are intact but esses on the nerves). The				
	document referenced					
		management and a referral				
		apist for therapy. This				
	· ·	urred for 1 of 1 resident				
	reviewed for accident	IS.				
	Findings included:					
		dmitted to the facility on				
		s that included end stage				
	renal disease (ESRD	) and chronic pain				
	syndrome.					
	A quarterly Minimum	Data Sat (MDS)				

Facility ID: 953008

If continuation sheet Page 2 of 26

	MENT OF HEALTH AN					FORM	2: 03/14/2023 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345304	B. WING			( 02/:	; 23/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	-	
				2727 SHAMROCK DRIVE			
ACCORD	IUS HEALTH AT MIDWOC	DD, LLC		CHARLOTTE, NC 2820	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	#1 was cognitively int required 1-person phy transfers, was able to with supervision assis 1-person physical assis 1-person physical assis further indicated that scheduled pain medic 7 days of opioid medi needed frequency and anticoagulant mediati An interview with Res 2/20/23 at 10:10 AM. bed with the lights off was in pain in her low extremity. Resident # level 12 on a 1-10 sca Resident #1 stated sh her lower back follow the facility van on 2/4, with the local dialysis explained she was sit the former Transporta caused Resident #1 to wheelchair and into th van. Resident #1 state wheelchair to land on the van floor. Resider Transportation Aide lo straps which secure to tightly strapped to the shoulder harness/lap place. The Transport firefighter for assistant wheelchair. Resident some pain; however,	act, no behavioral concerns, ysical assistance with self-propel her wheelchair stance, and walked with sistance. The assessment Resident #1 did not receive cations, but she did receive cations prescribed on an as d she received 7 days of ons. ident #1 was conducted on Resident #1 was lying in her and immediately voiced she rer back and right lower 1 described the pain as a ale (10 being the worst). he had some slipped discs in ing a fall during transport in /23 after an appointment center. Resident #1 ting in her wheelchair when tion Aide stopped which o be projected out of her he aisle on the floor in the ed at the time of the fall, the ecurely fastened to the van aps which caused the her when she fell out onto at #1 explained when the baded her in the van, the he wheelchair were not	F 68	34			

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	S FOR MEDICARE &					IO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · ·	TE SURVEY MPLETED	
		BENTI IOATON NOWBER.	A. BUILDING	G			
						С	
		345304	B. WING		0	2/23/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	ZIP CODE		
				2727 SHAMROCK DRIVE			
ACCORDI	US HEALTH AT MIDWO	OD, LEC		CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 684	Continued From pag	o 3	Ге				
F 004	Continued From pag		F 68	34			
		calized too much increase in					
		ing questioned about not					
	reporting the incident						
		ident stated eventually her					
	•	evel she felt needed to be					
	treated more than wi						
		t #1 explained on 2/6/23 she					
was		ency room evaluation and					
		nd discovered she had					
		bed disc" and provided pain					
		erred to the orthopedic					
	outpatient center.						
		former Transportation Aide					
		PM revealed she was					
	suspended from the	-					
		following a fall in the van					
	•	1. The Transportation Aide					
		duled to pick up Resident #1					
		23. Upon arrival to the d 10:30 AM, she loaded					
	•						
		van and quickly "fastened					
		rtation Aide explained shortly gan, she was approaching a					
		ection, she heard Resident					
		she looked back towards					
		covered Resident #1 was no					
		nair and was laying on the					
	-	her wheelchair no longer					
	fastened to the floor						
		expressed she immediately					
	•	k in the middle of the road,					
		g the side of the van to the					
	-	able to access Resident #1					
		ent #1 out of the floor but					
		cknowledged she needed					
		ident #1 back into her chair.					
		ide stated she got back out					
		nto the middle of the street"					

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	S FOR MEDICARE &				I	O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	E SURVEY PLETED
	CONTRECTION		A. BUILDING			
		0.1500.1				С
		345304	B. WING			/23/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ACCORDI	US HEALTH AT MIDWO	OD. LLC		2727 SHAMROCK DRIVE		
				CHARLOTTE, NC 28205		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pag	а <i>1</i>	F 68	4		
1 004			F 00	4		
	Transportation Aide	n down for assistance. The				
		sident #1 back in her				
		was brought back to the				
		n her room and did not report				
	-	1's assigned nurse nor				
		t time. The Transportation				
		not until the following				
	evening following a c	conversation with Resident				
	#1, (2/5/23) she noti	fied DON #1 via telephone to				
		he fall. The Transportation				
		ld her to come to the facility				
		nt for her and to ask the				
	-	omplete an incident report.				
		Aide further reported when				
		cility to write a statement, she				
		1 about completing an ich she refused stating she				
		e Transportation Aide				
		until the following day				
		ked further about the fall and				
	· /	e Transportation Aide stated				
		alled the facility when				
		nt falling in the van had				
		ent a staff member to assist				
	-	nt back in their chair, but				
	since this occurred of	on the weekend, she was not				
		therefore she flagged a				
		epartment instead. The				
	-	explained when she first				
		er in the fall of 2022, she was				
		ining and stated "they just				
	•	nd turned me loose." She				
		ever specifically provided				
	-	o if a resident fell during				
	transport. The Trans	portation Aide said she did				
	not think Resident #	1 was visibly injured and 911 or the facility on 2/4/23.				

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If continuation sheet Page 5 of 26

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345304	B. WING			_		C 23/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				2	2727 SHAMROCK DRIVE			
ACCORDI	US HEALTH AT MIDWOC	D, LLC		0	CHARLOTTE, NC 2820	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S	PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	≥ 5	F	684	-			
	Resident #1 if she wa	is ok but she was not						
	qualified to assess he	r for injuries and the						
		to place Resident #1 back						
		d what happened to which						
	Resident #1 replied s	he fell out of her wheelchair.						
	A review of the nurse	progress notes dated 2/4/23						
		here was no documentation						
	of Resident #1's fall fr	rom the wheelchair during						
	transport in the facility	/ van.						
	An incident report init	iated on 2/6/23 by the						
	-	rsing (DON #1) and dated						
		licated Resident #1 was						
	·	he facility from dialysis after						
		de secured Resident #1 in						
		vas on, she stopped at a red fell out of her wheelchair.						
		he Transportation Aide						
		sident #1 up from the vehicle						
		l and flagged down a fire						
		were able to assist Resident						
	#1 back into her whee	elchair.						
	A telephone interview	with the former Director of						
	Nursing (DON #1) on							
	,	ound 5 PM she received a						
	phone call from the T	ransportation Aide who told						
		fallen out of her wheelchair						
		n dialysis on the morning of						
		ucted the Transportation ity and tell Resident #1's						
	•	incident report. DON #1						
		ntact the facility on 2/5/23						
		able to provide any additional						
		the incident on 02/4/23						
	because she was sus	spended from the facility.						
	An interview with Nur	se #1 on 2/21/23 at 11:00						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345304	B. WING			_		C 23/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORD	US HEALTH AT MIDWOO	)D, LLC			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205	5		
(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 CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	AM revealed she was from 7AM to 7 PM on Nurse #1 indicated sh involving Resident #1 telephone call with Nu something unrelated a (current DON) notify Nurse #1 stated she was the incident because the oncoming shift rep she was not aware of #1 explained she was 2/5/23 when the Tran the facility and mention statement about some cigarettes involving R #1 admitted she did n incident report and to she was not completin statements for DON # and it would be handl following morning and further questions. Nur Resident #1 expresses at times over the wee pain was the same pa and she was not anyt assessment was com An interview with Nur AM revealed she was from 7 PM to 7 AM or #2 indicated she was 2/11/23 when she retu stated Resident #1 explain lower extremity discon scheduled PRN pain was not evaluated fur	a assigned to Resident #1 both 2/4/23 and 2/5/23. The did not learn about the fall until she was on a urse #4 on 2/6/23 about and overheard DON #2 Nurse #4 about the incident. Was asked if she knew about she had not been notified in port and Nurse #1 told her the incident herself. Nurse is on duty around 6 PM on sportation Aide arrived to oned she needed to write a e incident with buying tesident #1 of which Nurse not feel the need to write an ld the Transportation Aide ing one but to leave the #1 and/or the Administrator ed when they arrived the d therefore did not ask any rse #1 acknowledged ed mild asymptomatic pain ikend, but she thought the ain she routinely described, hing acute therefore no ipleted at the time. se #2 on 2/21/23 at 11:30 a assigned to Resident #1 in 2/4/23 and 2/5/23. Nurse not aware of the fall until urned to work. Nurse #2 opressed some hip and mfort and received her medication and Resident #1	F	684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	G		PLETED
		345304	B. WING				C 23/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	25/2025
ACCORDI	US HEALTH AT MIDWOO	DD. LLC			2727 SHAMROCK DRIVE		
					CHARLOTTE, NC 28205		
(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)		(X5) COMPLETION DATE
F 684	Continued From page	97	F	68	34		
		ten by the Nurse Practitioner					
		licated Resident #1 was r right leg pain. The note					
	detailed Resident #1	was involved in an incident					
	-	van over the weekend which g out of her wheelchair onto					
	the floor of the vehicle	•					
		ave her belts in place and					
		eg since the time of the an x-ray of the right hip and					
	pelvis was provided to	o rule out occult processes					
	(not detectable by clir	nical methods alone).					
	Attempts were made						
	Practitioner without su	uccess.					
	A review of the physic Resident #1 had an o hip and pelvis dated 2	rder for an x-ray of the right					
	A radiological report c	lated 2/6/23 revealed an					
	•	the right hip and pelvis the right hip and pelvis					
	noted.	actures of dislocations were					
		luation and was then					
	An interview with Nur	se #4 on 2/23/23 at 10:00					
	revealed she was the	nurse assigned to Resident					
		diological studies were due to complaints of pain in					
		hity and lower back region.					
	Nurse #4 indicated sh	ne was not aware that					
	Resident #1 fell in the approached her on 2/	e van until DON #2 /6/23 asking about the fall.					

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	-	ID HUMAN SERVICES				FORM	APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	PLE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			3	COMP	LETED
		345304	B. WING				C 23/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/	25/2025
	US HEALTH AT MIDWOO				2727 SHAMROCK DRIVE		
ACCORDI	US HEALTH AT MIDWOC				CHARLOTTE, NC 28205		
(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		(X5) COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From page	28	F	68	34		
	Nurse #4 indicated sh	ne was on the telephone with					
		nrelated topic and therefore					
		e was aware of the fall. she and Nurse #1 were					
	confused and both wi						
		ll in the van on 2/4/23. Nurse					
		1 seemed normal but had					
		n of pain after her PRN pain wided and therefore, she					
		e practitioner and obtained					
	an order for x-rays. N	urse #4 explained when the					
		she was not the nurse who					
		o Resident #1, but did arge per request to the ER					
		on 2/6/23. Nurse #4 further					
	•	resent when Resident #1					
		and was not aware of the					
	scheduled shift.	eturned to work on her next					
	A review of the Emerg	pency Room and FR					
	radiological studies da						
		essed to have lumbar spinal					
		mination by the ER provider Ilted in moderate spinal					
	canal stenosis at L3-L						
		usion. (Ligaments from the					
	spinal disc are intact l						
	presses on the nerves	,					
		eatment to include ongoing d a referral to an orthopedic					
	therapist for therapy.	· · · · · · · · · · · · · · · · · · ·					
	An interview with the	Medical Director (MD) on					
		revealed he was made					
		ving Resident #1 on 2/7/23					
		e facility for routine rounds.					
		d been told that Resident #1 ured in the facility van during					

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A DUM DIMO	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
A. BUILDING	
345304 B. WING	C 02/23/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2727 SHAMROCK DRIVE	
ACCORDIUS HEALTH AT MIDWOOD, LLC CHARLOTTE, NC 28205	
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PREFIX         (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX         (EACH CORRECTIVE ACTION SHOULD TAG         CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 684       Continued From page 9       F 684         by ER staff to have a disc protrusion and was experiencing lower lumbar pain that radiated to her sides. The MD indicated he could not say for sure that the injury was a result of Resident #1       F 684         a minor the injury was a result of Resident #1       Sustaining a fall during transport or not, but that it was a possibility.       An interview with the Administrator on 2/23/23 at 10:15 AM revealed during her morning commute to the facility on 2/6/23, she learned of the fall experienced by Resident #1 on 2/4/23 while in transport from the dialysis. The Administrator indicated when she arrived, she placed all staff involved on supension and began her investigation. She indicated that the Transportation Aide should have immediately pulled the van over, called emergency services to ensure Resident #1 was safe and without injury before moving her followed by contacting the facility Administrator and the Director of Nursing and/or the Manager on Duty.         On 2/20/23 at 5:20 PM, the facility Administrator and Regional Corporate Consultant were notified of the Immediate Jeopardy.       1. The facility failed to assess Resident #1 after she fell from her wheelchair while transported from dialysis in the facility on on 2/4/23. Resident #1 was lifted back into her wheelchair by the transporter and a member of a local fire department. Emergency Medical Services was not contacted, and the resident was transported back to the facility. Facility 5:20 PM. Lack of a comprehensive assessment resulted in a delay of transment for	

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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	
		345304	B. WING			02	C 2/23/2023	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDI	US HEALTH AT MIDWOO	DD, LLC			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205			
(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)	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE		
F 684	referral, pain manage On 2/6/23 Resident # back and right leg, the available in the facility ordered an x-ray whice Resident #1 subseque Room for evaluation p 2/6/23 where a CT so to L4-S1 and a referrat for ongoing care on 2 2. On 2/6/23 the Ass initiated an incident re- into the event and inco- resident, transporter, An audit of current rea- the last 30 days was Director of Nursing ar Clinical Services on 2 residents possibly affe Any unreported event incident report, invest resident completed by including safe reposit for any injury, an SBA resident medical reco Responsible Party we Director of Nursing or Clinical Services by 2 By 2/9/23 the Assistan Manager, Social Worl Clinical Services cono- current residents to ic- incidents during the la	required an orthopedic ment and therapy. 1 reported pain to her low e Nurse Practitioner, y assessed resident #1 and the was negative for fracture. ently went to the Emergency per resident's request on an reflected a bulging disc al to the orthopedic surgeon /6/23. sistant Director of Nursing eport and an investigation duded an interview with the and Director of Nursing. sidents transported during completed by the Assistant and Regional Director of /8/23 to identify any other ected by the same practice . as were documented on an igated, assessment of the y the licensed nurse ioning following assessment AR documented in the rd and the Physician and are notified by the Assistant regional Director of /9/23.	F	684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345304	B. WING				C /23/2023
NAME OF PI	ROVIDER OR SUPPLIER		- I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MIDWOC			27	727 SHAMROCK DRIVE		
				CI	HARLOTTE, NC 28205		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Manager and Regiona	nd Administrator, with and notification of I physician. nt Director of Nursing, Nurse al Director of Clinical	F 6	84			
	Services completed a incidents and acciden nursing assessment a responsible party and Root cause analysis f	its to ensure completion of a and notification to the I physician.					
	conducted by the Ass Medical Director, Adm Director of Clinical Se determined the transp emergency procedure	istant Director of Nursing, ninistrator and Regional ervices on 2/9/23 and it was porter failed to follow es, call 911 for help and nely which resulted in a delay					
	re-educated by the As and Administrator on Managing Incidents, t immediately to the Ad Director of Nursing, a to report concerns an persuading residents and allegations. Nurse the facility policy for a condition to include a assessment with rang injuries prior to reposi 2/9/23, the Assistant I Nurse Managers will a allowed to work, inclu	to include reporting events Iministrator or Assistant Iways encouraging residents d allegations, never to avoid reporting concerns ses were also educated on assessment with a change of complete head to toe ge of motion to identify itioning post fall. After Director of Nursing and					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345304	B. WING				C 23/2023
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ACCORDI	US HEALTH AT MIDWOO	DD, LLC			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Manager and Region Services re-educated agency staff regarding assessment, notificati and the physician follo incident/accident. Aft Director of Nursing ar ensure no nursing sta including any new hire without receiving this 4. The Assistant Dir Managers and Region review all incidents da clinical meeting to en- assessment and doct 12 weeks. 5 resident interviewed weekly by Manager for 12 week ensure the reporting of opportunities identifie corrected by the Assis Nurse Managers. 5. The results of the the Assistant Director QAPI meeting. A QA 2/9/23 to review this p will make recommend Date of IJ Removal: 2 The immediate jeopar and validated with a c 2/23/23 through staff training records. Inter was trained to perforr when any change of overbalized	al Director of Clinical all nursing staff, including g completion of an ion of the responsible party owing a reported ther 2/9/23, the Assistant and Nurse Managers will aff will be allowed to work, ed staff and agency staff, education. The completion of an unentation of the SBAR for s and 5 staff will be y the DON or Nurse is regarding incidents to of incidents. Any d during these audits will be estant Director of Nursing or ese audits will be reported by of Nursing at the monthly API meeting was held on olan. The QAPI Committee dations as needed. 2/10/23 rdy was removed on 2/10/23	F	684	4		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/1 FORM APPF OMB NO. 0938	ROVE
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345304	B. WING		C 02/23/202	23
	ROVIDER OR SUPPLIER	DD, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205	Ē	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP	(5) LETION ATE
F 684	assess a resident imm result in a progress n report, e-interact form medical provider and changes. All staff wei witness statements w provided for the Direct Administrator on the Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The re- as free of accident has supervision and assist accidents. This REQUIREMENT by: Based on record rev manufacturer's instru Medical Director, resi the facility failed to en according to manufact provide a safe van tra of her wheelchair ont of the van with her wil after the transportation stopped suddenly. T pain in her back and to the emergency dep moderate spinal cana- possible right paraces (ligaments from the s	verbalized they were to mediately and document the ote, complete an incident n, and notify both the the family to the noted re able to verbalize that yould be obtained and ctor of Nursing and/or the date of the incident. ards/Supervision/Devices (2) 5. ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent T is not met as evidenced iew, review of ctions, Nurse Practitioner, ident and staff interviews, nsure securement was cturer's recommendations to ansport. Resident #1 fell out o her right side on the floor heelchair on top of her body on van made a left turn and he resident experienced right leg and was later sent partment and diagnosed with al stenosis at L3-L4 with	F 68		n of	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3		PLETED
		345304	B. WING				C / <b>23/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT MIDWOO	DD, LLC					
					CHARLOTTE, NC 28205 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From page	2 14	F	68			
		or accidents (Resident #1).		00			
	The findings included	:					
		acturer's instructions for the which is the system used on					
	the facility's transport	van to secure residents who					
	are seated in wheelch indicated:	nairs during transport					
		ne 4 retractors, 2 in front of					
		in the rear metal locking link d to the van floor					
		nt with a seatbelt and					
	shoulder harness dev						
	- pull each belt shi place	ug to ensure it is locked into					
		dmitted to the facility on					
	4/5/22 with diagnoses renal disease (ESRD	s that included end stage					
	syndrome.						
	A quarterly Minimum	Data Set (MDS)					
ĺ		/14/22 indicated Resident					
		act, no behavioral concerns,					
	required 1-person phy transfers, was able to	self-propel her wheelchair					
	with supervision assis	stance, and walked with					
	· · ·	sistance. The assessment Resident #1 did not receive					
	scheduled pain medic	cations, but 7 days of opioid					
	medications prescribe						
	frequency and 7 days mediations.						
		ation Administration Record					
		y 2023 revealed Resident ceive dialysis three times per					
		ursday, and Saturday. The					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED C         NAME OF PROVIDER OR SUPPLIER       345304       B. WING       02/23/2023         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       02/23/2023		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345304 B. WING 02/23/202	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	`, ´			(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE			345304	B. WING				-
	NAME OF PI	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ACCORDIUS HEALTH AT MIDWOOD, LLC 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205	ACCORDI	US HEALTH AT MIDWOO	DD, LLC					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	ЗE	(X5) COMPLETION DATE
F 689       Continued From page 15       F 689         MAR indicated Resident #1 received dialysis on Saturday, 21/23.       F 689         An incident report initiated on 2/6/23 by the former Director of Nursing (DON #1) and dated 21/23 at 2.05 PM indicated Resident #1 was being transported to the facility from dialysis after the Transportation Aide secured Resident #1 in and ensured buckle was on, she stopped at a red light and Resident #1 fell out of her wheelchair. The report indicated the Transportation Aide attempted to pick Resident #1 up from the vehicle but was unsuccessful and flagged down a fire truck and firefighters were able to assist Resident #1 back into her wheelchair.         A review of the nurse progress notes dated 2/4/23 and 2/5/23 revealed there was no documentation of Resident #1's fail from the wheelchair during transport in the facility van.         A telephone interview with the former Director of Nursing (DON #1) on 2/20/23 at 12:50 PM revealed on 2/5/23 around 5 PM She received a phone call from the transportation aide who told her Resident #1's facility and tell Resident #1's nurse to complete an incident report. DON #1 stated she did not contact the facility on 2/5/23 and DON #1 was unable to provide any additional information regarding the incident on 02/24/23 because she was suspended from the facility.         A progress noted written by the Nurse Practitioner (NP) dated 2/6/23 indicated Resident #1 was referred by nursing for right leg pain. The note detailed Resident #1 was incident	F 689	MAR indicated Reside Saturday, 2/4/23. An incident report init former Director of Nut 2/4/23 at 2:05 PM ind being transported to t the Transportation Aid and ensured buckle w light and Resident #1 The report indicated t attempted to pick Resident truck and firefighters of #1 back into her where A review of the nurse and 2/5/23 revealed t of Resident #1's fall fit transport in the facility A telephone interview Nursing (DON #1) on revealed on 2/5/23 ar phone call from the tr her Resident #1 had to on the return trip from 2/4/23. DON #1 instru- Aide to go to the facilit nurse to complete an stated she did not cor and DON #1 was una information regarding because she was sus A progress noted writt (NP) dated 2/6/23 ind referred by nursing for	ent #1 received dialysis on iated on 2/6/23 by the rsing (DON #1) and dated licated Resident #1 was the facility from dialysis after de secured Resident #1 in vas on, she stopped at a red fell out of her wheelchair. the Transportation Aide sident #1 up from the vehicle I and flagged down a fire were able to assist Resident elchair. progress notes dated 2/4/23 here was no documentation rom the wheelchair during y van. with the former Director of 2/20/23 at 12:50 PM round 5 PM she received a ansportation aide who told fallen out of her wheelchair in dialysis on the morning of ucted the Transportation ity and tell Resident #1's incident report. DON #1 ntact the facility on 2/5/23 able to provide any additional the incident on 02/04/23 spended from the facility. ten by the Nurse Practitioner licated Resident #1 was or right leg pain. The note	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391			
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED			
		345304	B. WING				C /23/2023			
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE					
				2	2727 SHAMROCK DRIVE					
ACCORDI	US HEALTH AT MIDWOC	DD, LLC		c	CHARLOTTE, NC 28205					
(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)		(X5) COMPLETION DATE			
F 689	resulted in her slippin the floor of the vehicle Resident #1 did not h had pain to her right le incident. An order for pelvis was provided to (a concealed or unear disease). A review of the physic Resident #1 had an o hip and pelvis dated 2 A radiological report of x-ray was obtained of which indicated no fra noted. A nurse progress note 2/6/23 at 4:04 PM rev communicated by sta requested further eva transported to the ER A review of the Emerg radiological studies da Resident #1 was asse tenderness upon exat and the CT scan resu canal stenosis at L3-L paracentral disc protri referenced needed tre pain management and therapist for therapy. discharged back to the A 5-day facility reporter	van over the weekend which g out of her wheelchair onto e. It further indicated ave her belts in place and eg since the time of the an x-ray of the right hip and or rule out occult processes sily detected underlining cian's orders revealed order for an x-ray of the right 2/6/23. dated 2/6/23 revealed an the right hip and pelvis actures or dislocations were ed written by Nurse #4 dated realed the x-ray results were ff to Resident #1 who iluation and was then the via ambulance. gency Room and ER ated 2/6/23 indicated essed to have lumbar spinal mination by the ER provider ilted in moderate spinal 4 with possible right usion. The document eatment to include ongoing d a referral to an orthopedic	F	689						

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	ICAID SERVICES					RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DA	TE SURVEY MPLETED
	345304	B. WING			0	C 2/23/2023
NAME OF PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIUS HEALTH AT MIDWOOD, LI	с		2727	SHAMROCK DRIVE		
			CHA	ARLOTTE, NC 28205		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689 Continued From page 17 2/13/23 indicated on 2/4/2 sustained a fall during the facility van following an ap It further indicated the faci accident on 2/5/23 at 9:00 Transportation Aide. The of Resident #1 slid out of her injuries were noted. It furth reported to the Administrat Transportation Aide had no wheelchair to the van floor secured the seatbelt arour loaded into the van on 2/4, made a turn, the wheelcha Resident #1 slipped out of landed on top of Resident on 2/4/23 and on 2/5/23, F complaining of pain to her was given a PRN (as need which was somewhat help Resident #1 complained o burning sensation and an obtained which resulted in dislocations. Resident #1 t evaluation and was sent to (ER) where a computer to performed which indicated bulging disc at T4 (thoraci An interview with Resident 2/20/23 at 10:10 AM. Resi bed with the lights off and was in pain in her lower ba extremity. Resident #1 des level 12 on a 1-10 scale (1 Resident #1 stated she ha her lower back following a	transportation in the pointment from dialysis. lity was notified of the AM by the document indicated wheelchair and no her detailed Resident #1 tor that the of secured the r, nor did she tightly nd her when she was /23. When the van air began to roll, and it and the wheelchair #1. Later in the evening Resident #1 began lower extremities and ded) pain medication ful. On Monday, 2/6/23, f her leg hurting and x-ray was ordered and no acute fractures or then requested further to the Emergency Room mography (CT) was I Resident #1 had a c vertebrae #4).	F	689			

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	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED	
						С	
		345304	B. WING		02	2/23/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	IUS HEALTH AT MIDWOO	DD, LLC		2727 SHAMROCK DRIVE CHARLOTTE, NC 28205			
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
	with the local dialysis explained she was sit the former Transporta and suddenly stopper to be projected out of aisle on the floor in th the time of the fall, th securely fastened to a straps which caused her when she fell out #1 explained when th loaded her in the van wheelchair were not t wheelchair were not t wheelchair and the sl portion was not in plat she did not say anyth Aide before she was securement device not Transportation Aide fil for assistance to lift h	center. Resident #1 tting in her wheelchair when ation Aide made a left turn d which caused Resident #1 <sup>c</sup> her wheelchair and into the ne van. Resident #1 stated at e wheelchair was not the van using the securing the wheelchair to land on onto the van floor. Resident the straps which secure the tightly strapped to the houlder harness/lap restraint ice. Resident #1 indicated ing to the Transportation in transport about the	F 68	19			
	however, the intensity increased later that evening and over the next couple of days, but she was afraid to vocalized too much increase in severity to avoid getting questioned about not reporting the incident on the date of the occurrence. The Resident stated eventually her pain escalated to a level she felt needed to be treated more than with her routine PRN medication. Resident #1 explained on 2/6/23 she requested an emergency room evaluation and was sent to the ER and discovered she had suffered from a "slipped disc" and provided pain management and referred to the orthopedic outpatient center. An unsigned copy of a written statement by the former Transportation aide dated 2/5/23 read as follows: "Yesterday I went to pick up Resident #1						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	03/14/2023 APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE S COMPL	SURVEY ETED
		345304	B. WING			C 02/2	3/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP (	CODE		
			2	727 SHAMROCK DRIVE			
ACCORDI	US HEALTH AT MIDWOC	DD, LLC	0	CHARLOTTE, NC 28205			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	E	(X5) COMPLETION DATE
F 689	the chair, and I put he dialysis place. At the I stopped at the red lig Apparently, Resident I was not aware of it s went to her. I couldn't truck going by and I fl came to help. They as hurting anywhere, she she wanted to go to th They asked her if she asked to be put back asked me not to say a Aide told Resident #1 incident. Resident #1 to get in trouble, don't take her to the facility around." An interview with the on 2/20/23 at 12:05 P suspended from the fa- terminated on 2/9/23 involving Resident #1 stated she was sched from dialysis on 2/4/2 dialysis center around Resident #1 into the w her in." The Transport after the transport beg stop light at an interse #1 say "oh, oh" and si Resident #1 and disco longer in her wheelch floor of the van with h fastened to the floor of	r in the van, I secured her in er seat belt on and left the light after making 3 left turns ght and she fell off her chair. #1 took off her seat belt and so I put the van in park and I pick her up and I saw a fire agged them down. They sked Resident #1 if she was e said no. They asked her if he hospital, she said no. • was OK, she said yes and in her wheelchair. She anything. Transportation she had to report the said no don't, you're going a say anything, so I agreed to she was fine and moving former Transportation Aide M revealed she was acility on 2/6/23 and following a fall in the van . The Transportation Aide luled to pick up Resident #1 3. Upon arrival to the d 10:30 AM, she loaded van and quickly "fastened tation Aide explained shortly gan, she was approaching a ection, she heard Resident he looked back towards overed Resident #1 was no air and was laying on the er wheelchair no longer	F 689				

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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
		345304	B. WING				C 23/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ACCORDI	US HEALTH AT MIDWOO	DD, LLC			2727 SHAMROCK DRIVE CHARLOTTE, NC 28205		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	got out and slid along door where she was a and tried to lift Reside was unable to and ac assistance to lift Resid The Transportation Ai of the van and "ran in where she saw a fire "flagged" the fireman Transportation Aide d firefighter placed Res wheelchair and she w facility then left her in the fall to Resident #1 administration at that Aide reported it was r evening following a co #1, (2/5/23) she notifit make her aware of the Aide said DON #1 tole and leave a statement assigned nurse to cor The Transportation Ai she arrived at the faci approached Nurse # incident report of whice was not involved. The explained it was not u (2/6/23) she was aske was suspended. An interview with Nurs AM revealed she was from 7AM to 7 PM on Nurse #1 indicated sh involving Resident #1	a in the middle of the road, the side of the van to the able to access Resident #1 ent #1 out of the floor but knowledged she needed dent #1 back into her chair. de stated she got back out to the middle of the street" truck passing by and down for assistance. The etailed she and the ident #1 back in her vas brought back to the her room and did not report 's assigned nurse nor time. The Transportation not until the following onversation with Resident ed DON #1 via telephone to e fall. The Transportation d her to come to the facility t for her and to ask the mplete an incident report. de further reported when lity to write a statement, she 1 about completing an ch she refused stating she e Transportation Aide intil the following day ed further about the fall and	F	689			

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(X3) DATE SURVEY COMPLETED C 02/23/2023	
_	1
E COMPLE TE DATE	TION
	COMPLE

Facility ID: 953008

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345304	B. WING					C 23/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	, ZIP CODE		
ACCORDI	US HEALTH AT MIDWOC	D. LLC			727 SHAMROCK DRIVE			
		-;		C	CHARLOTTE, NC 28205			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI D TO THE APPROPRIA (CIENCY)		(X5) COMPLETION DATE
F 689	was not properly secu the transport on 2/4/2 by ER staff to have a experiencing lower lun her sides. The MD ind sure that the injury was sustaining a fall during was a possibility. A handwritten stateme Administrator dated 2 came into the Adminis 10:59 AM and stated transportation van on Aide who did not put I stated that Transporta stories and telling peo unstrapped her seat b Resident #1 also state Aide told her not to te messages regarding the Administrator asked her said she was okay, ju An interview with the A 10:15 AM revealed du to the facility on 2/6/2 experienced by Resid transport from the dia indicated when she ar involved on suspensio investigation. She ind Transportation Aide si pulled the van over, c ensure Resident #1 w before moving her foll	d been told that Resident #1 ired in the facility van during 3 and had been evaluated disc protrusion and was mbar pain that radiated to dicated he could not say for as a result of Resident #1 g transport or not, but that it ent written by the /6/23 indicated Resident #1 strator's office on 2/6/23 at she had fallen in the 2/4/23 with Transportation her seat belt on. Resident #1 tion Aide was fabricating ople that Resident #1 had belt but that was not true. ed that the Transportation II anyone and she had text the conversation. The low Resident #1felt and she st a little pain. Administrator on 2/23/23 at uring her morning commute 3, she learned of the fall ent #1 on 2/4/23 while in lysis. The Administrator rrived, she placed all staff on and began her icated that the hould have immediately alled emergency services to ras safe and without injury owed by contacting the and the Director of Nursing	F	689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMF	SURVEY PLETED		
		345304	B. WING				C 1 <b>23/2023</b>		
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
ACCORDI	US HEALTH AT MIDWOO	DD, LLC			727 SHAMROCK DRIVE HARLOTTE, NC 28205				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 689	Continued From page	e 23	F	689					
		M, the facility Administrator ate Consultant were notified pardy.							
	wheelchair while bein in the facility van on 2 10:30 AM which result when the van made a landed on top of her. into the wheelchair by and a member of the Resident #1 had pain back and right leg and the Emergency Room resident's request on reflected a bulging dis the orthopedic surged 2. On 2/6/23 the fac the transporter and th initiated an investigat the Administrator sus the facility van. A 24-	which continued to her low d was subsequently sent to n for evaluation per 2/6/23 where a CT scan sc to L4-S1 and a referral to on for ongoing care. cility immediately suspended ne Director of Nursing and ion of this event. On 2/6/23 pended all transports using -hour report was submitted							
	On 2/6/23 an incident investigation into the an interview with the Director of Nursing.	otective Services completed. t report was initiated and an event began and included resident, transporter, and							
	the last 30 days was Director of Nursing ar 2/8/23 to identify any affected by the same	sidents transported during completed by the Assistant nd Nurse Managers on other residents possibly practice. Any unreported nted on an incident report,							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 02/23/2023				
		345304	B. WING							
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	·				
ACCORDIUS HEALTH AT MIDWOOD, LLC				2727 SHAMROCK DRIVE CHARLOTTE, NC 28205						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	D BE COMPLETION				
F 689	investigated, an asse completed, document and Physician and Re notified by the Assista Nurse Managers by 2 By 2/9/23 the Assista Manager, Social Worf Clinical Services cond current residents to ic incidents during the la incidents identified we Director of Nursing ar investigation, residen notification of respons 2/9/23 the Assistant D Manager and Regions Services completed a incidents and accider nursing assessment a responsible party and Root cause analysis f conducted by the Ass Medical Director, Adm Director of Clinical Se determined the transp manufacturer guidelir wheelchair in the van 3. Beginning 2/6/23 services will be used permanently, facility v Administrator until the from the facility parkir appointments were so transportation service Office Manager on 2/	ssment of the resident ted in the medical record esponsible Party were and Director of Nursing and /9/23. In Director of Nursing, Nurse ker and Regional Director of ducted interviews with lentify any unreported ast 30 days. Any new ere reported to the Assistant of Administrator for further t assessment and sible party and physician. By Director of Nursing, Nurse al Director of Clinical record review of all to to ensure completion of a and notification to the l physician. For Resident #1 was istant Director of Nursing, ninistrator and Regional ervices on 2/9/23 and it was porter failed to follow tes for securing a prior to transport.	F	689	9					

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DEPARTMENT OF HEALTH AND HUMAN S CENTERS FOR MEDICARE & MEDICAID S	-					FORM	0: 03/14/2023 MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE	R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345304	B. WING			_		C 23/2023
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205						
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
<ul> <li>F 689 Continued From page 25 change of system by the Regiona Clinical Services on 2/6/23.</li> <li>4. The Nurse Manager trained th Business Office Manager to randor resident being secured in the outs van prior to leaving the facility, trai instruction to stop the transport in wheelchair is not secured or the signate and report to the Administrat Director of Nursing immediately. The transportation service provided the Director of Operations with proof of securing a resident in the outside prior to moving the van.</li> <li>The results of these audits will be Assistant Director of Nursing at the meeting. A QAPI meeting was he review this plan. The QAPI Commission recommendations as needed. Date of IJ Removal: 2/10/23</li> <li>The credible allegation was removing with a validation of the credible all completed on 2/23/23 through obsiniterviews and in-service training Observation confirmed the facility their own transportation van. Staff verbalize the process of the facility the nurse and administrative staff and validate their observations an immediately and document all need Review of audit reports verified the monitoring to ensure residents we transportation.</li> </ul>	he Assistant omly observe side transport ining included the event the eatbelt is not in tor or Assistant The outside e Regional of training on transport van reported by the e monthly QAPI eld on 2/9/23 to sittee will make ved on 2/10/23 egation was servations, staff records. no longer uses if were able to y for notifying of any incident d knowledge cessary details. e system for	F	589				

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