(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	ETED
					С	
		345130	B. WING		07/28	8/202 <u>3</u>
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT CONCO	RD		LAKE CONCORD ROAD NE		
			l co	NCORD, NC 28025	1	
(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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	investigation survey to 7/28/2023. The fa compliance with the r	requirement CFR 483.73, Iness. Event ID # FK6F11.	F 000			
	survey were conductor 7/21/2023. The exit of phone on 7/28/23. The changed to 7/28/23. following intakes wern NC0000203632, NC0 NC00201143, NC002 NC00195684, NC00201	onference was conducted by herefore, the exit date was Event ID# FK6F11. The e investigated: NC00204981, 00203301, NC00202698, 000942, NC00197402, 195274, NC00195066, 194204, NC00200697,				
	8 of 35 complaint alle deficiency.	gations resulted in				
	CFR 483.12 at tag F6	was identified at: 580 at scope and severity J. 600 at scope and severity J. 697 at scope and severity J.				
	The tags F600 and F Quality of Care.	697 consituted Substandard				
	removed on 7/26/202 conducted on 7/27/23					100.005
F 580 SS=J		jury/Decline/Room, etc.) l)(i)-(iv)(15)	F 580		8	3/26/23
	§483.10(g)(14) Notific	cation of Changes.				
LABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X	(6) DATE
Electronic	cally Signed				0	8/20/2023

(X2) MULTIPLE CONSTRUCTION

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>
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F 580	consult with the reside consistent with his or representative(s) where (A) An accident involves a consistent with his or representative(s) where (A) An accident injury and his physician intervention (B) A significant chain mental, or psychosocideterioration in health status in either life-th clinical complications (C) A need to alter the aneed to discontinue treatment due to advict commence a new for (D) A decision to train resident from the facility when making not (14)(i) of this section, all pertinent informati is available and proviphysician. (iii) The facility must a resident and the resident and the resident there is (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must are stated to the resident to	nediately inform the resident; ent's physician; and notify, her authority, the resident en there isving the resident which has the potential for requiring n; age in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or after or discharge the lity as specified in ification under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the elso promptly notify the dent representative, if any, are or roommate assignment 10(e)(6); or ent rights under Federal or ent sas specified in paragraph in the record and periodically mailing and email) and	F 58		

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		345130	B. WING	$ \bot$ \bot \bot \bot \bot \bot	C 07/28/2023
NAME OF P	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	\
			, 51	15 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CONC	טאט	С	ONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				BETTOLENOTY	
F 580	Continued From pag	ge 2	F 580		
	Admission to a com that is a composite of §483.5) must disclosits physical configur locations that compliant, and must spectroom changes betwounder §483.15(c)(9). This REQUIREMENT by: Based on record repractitioner (NP), phinterviews, the facilities resident who experied of 3 residents investigated that it is fall on 6/2/2023 and hip pain to Physical 6/3/2023. PT #1 reproduced to a nurse. Resident right hip pain when son 6/5/2023. NP#2 of hip, which revealed bone in the leg). Reproduced bone in the leg). Reproduced bone in the leg hospital on 6/6/2023 partial hip replacem limmediately Jeopar Resident #94 report to PT #1 and the MI Jeopardy was remofacility implemented	distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct ify the policies that apply to seen its different locations		PROBLEM IDENTIFIED: During Annual Survey in July 2023, it was identified based on record reviews, resident, family, nurse practitioner (NP), physician (MD), and staff interviews, the facility failed to notify the MD of a reside who experienced pain following a fall for of 3 residents investigated for notification of changes (Resident #94). Resident #8 sustained a fall on 6/2/23 and reported the fall and right hip pain to Physical Therap (PT) #1 on 6/3/23. PT #1 reported the fand the hip pain to a nurse. Resident #8 reported the fall and right hip pain when she was assessed by NP #2 on 6/5/23. NP #2 ordered an x-ray of the right hip, which revealed a fractured femur (the lobone in the leg). Resident #94 was sent to the hospital on 6/6/23 at 12:30am and had partial hip replacement surgery on 6/7/23.	nt 1 1 14 14 ne ist all 94
	remain out of compl level of D (not actua more than minimal h jeopardy) for the fac and to ensure monit	iance at a scope and severity I harm with the potential for narm that is not immediate ility to complete staff training oring systems put in place		Immediate Jeopardy began on 6/3/23 when Resident #94 reported the fall and right hip pain to PT #1 and the MD was not notified.	
	are effective.			Immediate Jeopardy was removed on	

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01128/2023
NAME OF FROVIDER OR SUFFLIER			515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CON	CORD			
				CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 580	Continued From pa	age 3	F 58		
	The findings includ	led:		7/26/23 when the facility implemented credible allegation of Immediate removal.	
	Resident #94 was	admitted to the facility on			
	6/2/2023 with diag frequent falls.	noses to include dementia and		The facility remains out of compl scope and severity of a level D (harm with the potential for more	not actual
	Nurse #6 dated 6/2	sing assessment recorded by 2/2023 documented that alert and oriented to person		minimal harm that is not immedia jeopardy) for the facility to compl training and to ensure monitoring put in place are effective.	ate lete staff
	7/20/2023 at 3:30 evening of 6/2/202 assistance to use	onducted with Resident #94 on PM. Resident #94 reported the 3 she used her call light to get the bathroom, but no staff so she got up to go to the		ADDRESS HOW CORRECTIVE WILL BE ACCOMPLISHED FOR RESIDENT(S) HAVING BEEN AFFECTED:	
	bathroom on her o fell on the floor out her right hip. Resid started yelling for h	wn. Resident #94 reported she side of the bathroom and hit lent #94 explained that she nelp immediately, and her nt #50) yelled for help, too.		The facility failed to notify the ph and/or resident representative at Resident #94 reported to PT #1 that she had fallen in her room o	ter on 6/3/23
	Resident #94 said to her room, picked bed. Resident #94 and she told the N	that 2 nurse aides (NAs) came d her up and put her back in recalled her leg hurt terribly As her leg was hurting. ained the therapist (PT#1)		On 6/3/23, the PT evaluation rev Resident #94 reported to the PT had fallen on 6/2/23 in her room not reported the incident to the fa staff. The PT also reported that	that she and had acility
	#1 she did not thin she fell the night b she would talk to the	ay to see her and she told PT k she could stand up because efore. PT #1 told Resident #94 ne nurse. Resident #94 eg "hurt so bad all the time"		resident complained of right hip this was reported to the Nurse # hall who reported she would follo obtain an order for an x-ray.	1 on the
	and every time sta them that it hurt. F came in to see her and she told the N having right hip pa	ff moved her in bed, she told Resident #94 said the NP #2 on Monday morning 6/5/2023 P that she had fallen and was in.		On 7/21/23, the Director of Nursi to Nurse #1 and she denied any knowledge of Resident #94 repo she had fallen or that the PT or a staff member reporting to her that Resident #94 had fallen. In additional the process of the process	rting that any other at tion,
	A follow-up intervie	w was conducted with		Nurse #1 was asked if Resident	#94

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		345130	B. WING		C
NAME OF D	ROVIDER OR SUPPLIER	343130		STREET ADDRESS CITY STATE ZID CODE	07/28/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT CON	CORD		515 LAKE CONCORD ROAD NE	
				CONCORD, NC 28025	
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F 580	Continued From p	page 4	F 58	0	
	Resident #94 on 7	7/21/2023 at 1:58 PM. Resident		requested pain medication or had sig	ns of
	#94 recounted the	e fall on 6/2/2023 and added		symptoms of pain and Nurse #1 repo	
	that she thought s	she fell after dinner but could not		no.	
		the time. Resident #94			
	recounted that she	e "screamed and screamed"		On 7/20/23, the Therapy Director spo	oke to
	(for help) and "2 la	adies (NAs) came and got me		the PT that was working on 6/3/23 ar	nd
	into bed, I scream	ed in pain the entire time."		she reported that Resident #94 had	
	Resident #94 repo	orted she had called her family		reported to her that she had fallen on	
	member on 6/2/20	023 to report the fall.		6/2/23 while attempting to go to the	
				bathroom. The PT reported that the	
		er of Resident #94 was		roommate also reported that the residual	
		one on 7/20/2023 at 4:19 PM.		had fallen on the previous day (6/2/2	3).
		er reported that Resident #94			
		PM on 6/2/2023 to tell him that		On 6/5/23, after the NP reported that	
		d she was having pain in her		Resident #94 reported a fall on 6/2/2	
		ember explained that Resident		Director of nursing completed a follow	
		iff members had picked her up		interview and Resident #94 reported	
	1	ne didn't think he needed to call		she had fallen while attempting to go	
		rt the fall. The family member		the bathroom and had gotten herself	
	1 -	to visit Resident #94 on		off the floor and had not reported this	i to
		ed to Nurse #1 and reported		the staff.	
		had fallen and was having pain.		On G/E/22 Unit Manager #1 and the	
		er explained that he visited 6/4/2023 and asked the nurse		On 6/5/23, Unit Manager #1 and the Admissions Director spoke to Reside	nt
		ting Resident #94 a walker, and		#94 s family member who reported	
		d the fall and pain to Nurse #8.		on 6/2/23 Resident #94 had reported	
		it the nurse's response, the		him that she had fallen on the way to	
		id the nurse did not say		bathroom and that she was having a	
		e reported fall. The family		pain. The family member reported th	
		he had called the admission's		reported that Resident #94 was havir	
		left her a voice mail reporting		pain to the charge nurse.	.9
	the fall on Monday				
		•		On 6/5/23 during the NP initial	
	A physical therapy	y evaluation conducted by PT #1		assessment, Resident #94 reported t	hat
		23 documented that Resident		she had fallen on 6/2/23 in her room	
	#94 reported right	hip pain from a fall 6/2/2023.		attempting to go to the bathroom and	
		d that Resident #94 required		having right hip pain.	
	moderate assistar	nce to stand with right-sided			
	leaning noted. The	e note documented the physical		On 7/17/23 the facility investigation b	v the

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				15 LAKE CONCORD ROAD NE	
ACCORD	IUS HEALTH AT CONC	CORD		CONCORD, NC 28025	
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F 580	Continued From pa	age 5	F 580		
	therapist notified th	ne nurse (unnamed) and was		Director of Nursing revealed that the	
	told nursing would			Nurse Practitioner was informed of	
		•		Resident #94□sw fall on 6/2/23 during h	ner
	PT #1 was intervie	wed by phone on 7/21/2023 at		initial assessment on 6/5/23 by the	
	2:49 PM. PT#1 rep	orted she evaluated Resident		resident. In addition, further review of the	ne
	#94 on 6/3/2023 ar	nd she attempted to stand		medical record revealed that there was	no
	Resident #94 at the	e bedside, but Resident #94		fall nursing assessment documentation	or
		d. The PT explained that		physician/physician extender notification	
		her roommate, Resident #50,		documentation by the licensed nurse of	
		ent #94 fell the night before.		the 6/2/23 fall until 6/5/23.	
		rted right hip pain to her with			
		4 was unable to stand during		The Director of Nursing completed the	
		out moderate assistance and		interviews on 7/23/23. The interviews	
		right. PT #1 indicated she		revealed that the licensed nurses and	
	-	station and looked for a nurse		certified nursing assistants that worked	l l
		all and the pain that Resident		6/2/23, 6/3/23, and 6/4/23 reported that	l l
		sing. PT #1 reported an		Resident #94 did not report to them that	
		d told her she would get an		she had fallen on 6/2/23.	
	1	or Resident #94. PT#1 was not		The licensed purees contified pureing	
		day she evaluated Resident		The licensed nurses, certified nursing	
		able to provide the name of ne she reported to the nurse.		assistants, and certified medication aide interviews by the Director of Nursing of	,
	the nuise of the till	ne she reported to the hurse.		staff that worked on 6/2/23, 6/3/23, and	
	Nurse #1 an agen	cy nurse, was assigned to		6/4/23 per the nursing assignment shee	te
		/3/2023 on the day shift (7:00		revealed that Resident #94 did not repo	
		lultiple attempts to contact		the fall to the assigned nurse, certified	
	1	erview were unsuccessful		nursing assistant, or certified medication	n
		ills with voice messages and		aide.	
	text messages.				
	NA #1 was into	wood on 7/20/2022 at 44:E7 AM		On 7/17/23, Nurse #3 (Weekend	
		wed on 7/20/2023 at 11:57 AM. e was assigned to Resident		Supervisor) interview with the Director of	⁷¹
		•		Nursing revealed that Resident #94 did	
		/2023 for the day shift. NA #1 #94 had pain during the		not express pain concerns and she did not observe signs or symptoms of	
		y moved her in bed. NA #1		excruciating pain on 6/3/23 and 6/4/23.	
		eported the pain to Nurse #1		Nurse #3 also reported that Resident #9	14
		1 reported Resident #94 did not		as well as the other nursing staff to	, T
		lay shift for 6/3/2023 or		include the PT who worked on 6/3/23 at	nd
		equired incontinence care in		6/4/23 did not report that Resident #94	

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C 07/28/2023		B. WING	345130		
\ 	STREET ADDRESS, CITY, STATE, ZIP CODE	S ⁻	UPPLIER	OF PROVIDER OR SUPPLIER	NAME OF PR
	515 LAKE CONCORD ROAD NE	, 51			
	CONCORD, NC 28025	С	AI CONCORD	ORDIUS HEALTH AT CONC	ACCORDI
(X5)	PROVIDER'S PLAN OF CORRECTION	ID	SUMMARY STATEMENT OF DEFICIENCIES	ID SUMMARY	(X4) ID
COMPLETION DATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX TAG	H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION)	IX (EACH DEFICIE	PRÉFIX TAG
		F 580	From page 6	580 Continued From pa	F 580
	had fallen on 6/2/23.		se of the right hip pain.	bed because of the	
	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) HAVING POTENTIAL FOR THE SAME ISSUE NEEDING TO BE ADDRESSED:		w was conducted with NA #2 on at 2:28 PM. NA #2 reported she was concluded Resident #94 on 6/3/2023 for the shift. The NA explained that Resident ained of pain in her hip, but she did not my nurse because she had observed	7/20/2023 at 2:28 I assigned to Reside afternoon shift. The #94 complained of	
of	All current residents are at risk because of this deficient practice.		orting the pain a nurse. NA #2 she did not remember the nurse that ne report from PT #1, but she had seen	PT #1 reporting the explained she did received the report	
	Starting on 7/21/23, the Director of Nursing, Unit Managers, and/or designee conducted an audit of the medical records to include progress notes, outside provider notes, incident reports, medication administration records,		them talking. Resident #94 was unable of bed during the afternoon shift on ecause of the pain she experienced g. NA #2 reported she did not notice in Resident #94's right hip.	to get out of bed do 6/3/2023 because with moving. NA #2	
/	physician orders, and nursing shift reports of current residents residing in the facility for the last 60 days to ensure the physician/physician extenders and resident representatives have been		no evidence in the medical record that or any other staff notified the physician it #94's fall and subsequent pain or that as ordered on 6/3/2023.	Nurse #1 or any ot of Resident #94's f an x-ray was order	
n	notified of any resident falls or changes in condition.		w was conducted with NA #4 by phone 23 at 11:10 AM. NA #4 reported she desident #94 with incontinence care on	on 7/25/2023 at 11	
	Identified concerns were addressed and corrected on or before 7/25/23.		uring the afternoon shift and Resident intense pain all shift. NA #4 reported oted to provide incontinence care by	#94 was in intense	
0	Starting on 7/21/23, the Director of Nursing and/or designee will complete interviews of the alert current residents to ensure resident concerns within the last		d this caused Resident #94 to "scream n" in pain. NA #4 explained that she another NA to assist her with care. NA d she told Nurse #2 that Resident #94	herself, and this ca and scream" in pai had to get another #4 reported she tol	
t	accidents, pain management, medication/treatments and other resident care concerns have been identified and reported to the physician/physician extenders.		vas interviewed on 7/19/2023 at 4:05 le reported that she was assigned to 194 during the afternoon shift on 6/2, and 6/5/2023 had not expressed she an at all to her when Nurse #2 conducted	Nurse #2 was inter PM and she report Resident #94 durin 6/3, 6/4, and 6/5/20 was in pain at all to	
	corrected on or before 7/25/23. Starting on 7/21/23, the Director of Nursing and/or designee will complete interviews of the alert current residents to ensure resident concerns within the last 60 days to include incidents and accidents, pain management, medication/treatments and other resident care concerns have been identified and reported to the physician/physician		intense pain all shift. NA #4 reported of the top to the top	#94 was in intense she attempted to p herself, and this ca and scream" in pai had to get another #4 reported she tol was in pain. Nurse #2 was inter PM and she report Resident #94 durin 6/3, 6/4, and 6/5/20 was in pain at all to	

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F 580	Continued From p	nage 7	F 580		
1 000	Continued From p	rage r	1 300		۵.
	A f-11	2000 11th Name of #2 are 7/25/2022		Identified concerns were addressed an	a
		ew with Nurse #2 on 7/25/2023		corrected on or before 7/25/23.	
		ed no one reported Resident cing pain on 6/3/2023, 6/4/2023,		Starting on 7/21/23, the Director of	
		g her afternoon shift. Nurse #2		Nursing and/or designee will complete	
	,	ne reported Resident #94 had a		interviews of the facility staff to include	
		encing hip pain. Nurse #2		licensed nurses, certified nursing	
		en she performed the pain		assistants, certified medication aides,	
		esident #94 on 6/2/2023,		dietary, housekeeping/laundry, agency	
		3, and 6/5/2023, the resident		new hire and PRN staff to ensure all	,
	denied pain. Nurs	se #2 reported she did not		resident changes in condition or any	
	notice swelling or	bruising of Resident #94's right		reported concerns within the last 60 da	ys
	leg during any of l	her shifts. Nurse #2 reported		were identified and reported to the	
		the fall when she arrived for		Director of Nursing, Unit Manager(s),	
		for the afternoon shift. Nurse		and/or the Nursing Supervisor and	
	•	vaited for the x-ray results to call		subsequently to the physician/physician	า
		ut was told the results were not		extenders.	
		e end of her shift. Nurse #2			
		g any assessments on Resident		Identified concerns were addressed an	d
	#94, except for the	e daily shift pain assessment.		corrected on or before 7/25/23.	
		erviewed by phone on 7/20/2023		ADDRESS WHAT MEASURES WILL E	BE
		ne reported she remembered		PUT IN PLACE OR SYSTEMIC	
		mily member requesting a		CHANGES MADE TO ENSURE THAT	
		shift (3:00 PM to 11:00 PM) on		THE IDENTIFIED ISSUE DOES NOT	
		ed the family member reporting sexperiencing pain.		OCCUR IN THE FUTURE:	
				Starting on 7/21/23, the Staff	
		dence in the medical record that		Development Coordinator (SDC), Direct	
		#8, or any other staff notified the		of Nursing, and/or designee will comple	ete
		dent #94's fall and subsequent		education with staff including licensed	
	pain or that an x-r	ay was ordered on 6/4/2023.		nurses, certified nursing assistants,	
	ND#4	. 7/00/0006		certified medication aides, dietary, ther	ару
		ewed on 7/20/2023 at 12:14 PM.		department, housekeeping/laundry,	
	-	at a review of the on-call logs		agency, new hire and PRN staff regard	- 1
		came from the facility to report a		reporting changes in condition including	9
	6/4/2023.	sident #94 on 6/2, 6/3, or		incidents and accidents, pain	
	01412023.			management changes, medication/treatment concerns, resider	nt
	I		1	The alcalon, a cauncil Concerns, Tesluci	IL

Facility ID: 953050

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 07/28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	~ -
			- , ,	515 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CON	CORD		CONCORD, NC 28025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 580	Continued From page	age 8	F 580		
	NA #3 was intervie	wed on 7/21/2023 at 4:49 PM.		care concerns and any resident/family	
	NA #3 explained s	he was working on day shift on		reported concern to the licensed nurse	
	6/2/2023 when Re	sident #94 was admitted to the		and to the Director of Nursing, Unit	
	facility, and she ha	id assisted her to the bathroom.		Manager(s), and Nursing Supervisor(s))
	NA #3 indicated R	esident #94 was able to		and subsequently to the	
		elchair and to the toilet by		physician/physician extenders as	
		ing to sit and the resident had		indicated.	
		transfers or any episodes of			
		2/2023. NA #3 reported she		Education was completed with staff on	or
		n 6/5/2023 and was assigned		before 7/25/23.	
		the day shift, and when she			
		de care, Resident #94 yelled in		Education will be ongoing with newly h	ired
		eg!" NA #3 reported on Monday		staff and agency staff.	
		ay shift Resident #94 was in		Starting on 7/21/22 the Staff	
		inence brief on and required NA #3 reported she went to		Starting on 7/21/23, the Staff Development Coordinator (SDC), Direct	ator
		when they returned to		of Nursing, and/or designee will comple	I
	_	om, NP #2 was at the bedside.		education with staff including licensed	
		Resident #94 was unable to		nurses, including agency nurses, newly	,
		ut yelling out in pain. NA #3		hired nurses, and PRN nurses, regardi	I
		to get Nurse #6 and when she		immediate notification and documentat	_
		nt #94's room, NP #2 was at		of resident changes in condition includi	
		3 described that Resident #94		incidents and accidents, pain	
	experienced pain a	all day on 6/5/2023 and she had		management changes,	
	to get another NA	to assist her with incontinence		medication/treatment concerns, resider	nt
	care for Resident	#94 because of her pain level.		care concerns and any resident/family	
	NA #3 reported Re	sident #94 said her pain was in		reported concerns to the	
		was very sharp and severe		physician/physician extenders and the	
		ovement and turning for		resident representatives and to docume	I
		was unbearable painful. NA#3		notifications in the medical record. After	er
		23 Resident #94 was able to		hours, licensed nurses will notify the	
		oom, but she stayed in bed all		on-call provider and document notificat	ion
	the bed.	received incontinence care in		in the medical record. Education was completed with staff on or before 7/25/	23.
	. •	ritten by NP #2 dated 6/5/2023		Education will be ongoing with newly h	ired
		lent #94 reported to her that on		staff and agency staff.	
		npted to go to the bathroom pain in her right hip since (the		On 7/21/23, the Staff Development	
	i anu nau a fall Wilh	pain in her right flip since (the		On 1/2 1/23, the Stall Development	1

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER		, ,	STREET ADDRESS, CITY, STATE, ZIP CODE	07/28/202 <u>3</u>
NAME OF T	NOVIDEN ON GOLT EIEN			515 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CON	ICORD			
				CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 580	Continued From p	page 9	F 580		
	fall).	3		Coordinator was made aware by the	
	1 '	ted Resident #94 had increased		Director of Nursing that she will be	
		ith touch, no bruising was		responsible for verifying that educatio	n
		appeared to be swollen. The		has been completed by the required s	
		Resident #94 had pain to the		members by using the facility personr	
		t Resident #94 rated as "4" and		roster and the nursing, dietary, therap	
		ning". The note documented		and housekeeping/laundry staffing	
	Resident #94 had	as needed (acetaminophen) at		schedules to include new hires, agend	су
	this time", and sta	aff were to continue to monitor		staff, and PRN staff.	
	Resident #94 unti	I an x-ray result were received.			
				Staff members will not be permitted to	
		ewed on 7/21/2023 at 2:45 PM.		work in the facility until they have rece	eived
	•	ne was performing the		the appropriate education.	
		sment on Resident #94 on			
		esident #94 reported the hip		Education will be ongoing with newly	hired
		#2 explained she ordered an		staff and agency staff.	
	1	#94's hip and when the x-ray			
		as determined Resident #94		Ongoing education will be provided by	
		e was sent to the hospital for		Staff Development Coordinator, Direct	cior
		2 reported she had not received fall or reports of pain prior to		of Nursing, Unit Manager(s), Nursing Supervisor(s) and/or designee.	
		eported she would have		Supervisor(s) and/or designee.	
		on 6/3/2023 of Resident #94's		On 7/25/23, the Director of Nursing	
		en notified of the fall with pain.		educated the Therapy manager to en	sure
		pa		that therapists, including occupationa	
	A hip x-ray dated	6/5/2023 and read at 9:39 PM		therapists, occupational therapy	
		apital fracture with moderate		assistants, physical therapist, physica	ıl
		ute right hip fracture).		therapy assistants, and speech therap	oists,
	,			including weekend therapists, newly h	nired
	A nursing note da	ted 6/6/2023 at 12:31 AM		therapists, and PRN therapists report	
		esults of the hip x-ray were		resident observed and reported falls t	o the
		scility at 11:45 PM on 6/5/2023.		therapy manager and the Director of	
		as paged, and the nurse		Nursing immediately.	
		to send Resident #94 to the			
		ation for the right hip fracture.		Starting on 7/25/23, the therapy mana	ager
		nted that Resident #94 left the		will educate therapists including	
	facility by ambula	nce at 12:30 AM.		occupational therapists, occupational	
		an automatic (CD)		therapy assistants, physical therapist,	
	∣ ≀ne emergency d	epartment (ED) provider note		physical therapy assistants, and spee	cn

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		345130	B. WING	/ \	C 07/28/202<u>3</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT CONC	CORD	, ,	515 LAKE CONCORD ROAD NE	
ACCORDI	US REALIR AT CONC	OND	•	CONCORD, NC 28025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 580	Continued From pa	age 10	F 580		
	dated 6/6/2023 at 1	1:28 AM documented Resident		therapists, including weekend therapist	s,
	#94 presented with	right hip pain that was found		newly hired therapists, and PRN	
	to be fractured on a	an x-ray obtained outpatient		therapists report resident observed and	
	earlier that day. Re	esident #94 reported she fell		reported falls immediately to the therap	y
		l has had right hip pain ever		manager and the Director of Nursing.	
		cumented the x-ray obtained			
	•	ed a right hip fracture. On		Staff members will not be permitted to	
		cian noted tenderness to the		work in the facility until they have receive	/ed
		formity. Repeat x-rays		the appropriate education.	
		l a closed subcapital right			
		re. There was no pain rating, of medications administered for		Education will be ongoing with newly hi	rea
				staff and agency staff.	
	l ·	urgery was consulted and at nded for Resident #94 to be		INDICATE HOW THE FACILITY PLANS	2
		her NPO (nothing by mouth)		TO MONITOR ITS PERFORMANCE TO	
	status.	There is a meaning by meaning		MAKE SURE SOLUTIONS ARE	
	otatao.			SUSTAINED. THE FACILITY MUST	
	An orthopedic trau	ma consult note dated		DEVELOP A PLAN FOR ENSURING	
		AM documented: Patient		THAT CORRECTION IS ACHIEVED AN	ND
	(Resident #94) rep	orted on Friday 6/2/2023 she		SUSTAINED. THE PLAN MUST BE	
	was attempting to	get up to the bathroom and fell,		IMPLEMENTED AND THE CORRECTI	VE
		t hip. She reported immediate		ACTION EVALUATED FOR ITS	
		and being unable to get up		EFFECTIVENESS:	
		istory and physical noted:			
	-	nity: skin intact without		The facility will monitor its performance	
		gth short in comparison to		the Director of Nursing, Unit Managers,	
	ļ ,	eft leg) and hip held in external		and/or designee conducted an audit of	
		otated to the right). Endorses vith heel strike (touching heel		medical records including progress note outside provider notes, incident reports	
	,	mobility)." Details in the		medication administration records,	,
		an included the right femoral		physician orders, and nursing shift repo	orts
		discussed with Resident #94		of current residents residing in the facili	
		dation was to proceed with the		since the last audit to ensure the	
		ty, to which she agreed. This		physician/physician extenders and	
		ussed with a family member		resident representatives have been	
		ated Resident #94 was		notified of any resident falls or changes	in
	competent to sign l			condition and that documentation of	
				notifications can be found in the resider	nt
	An orthopedic trau	ma operative (surgical) report		record.	

Facility ID: 953050

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NAME OF P	ROVIDER OR SUPPLIER	345130	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORD	US HEALTH AT CON	CORD		15 LAKE CONCORD ROAD NE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 580	dated 6/7/2023 do right partial hip rep date for a right hip An interview was of 7/21/2023 at 11:54 medical group has NP was available amedical questions reported that the factor on 6/2, 6/3, or 6/4/delaying treatment could have resulte Resident #94. The Director of Nu on 7/21/2023 at 3: that she had though reported the fall to NP #2 assessed hour aware of the placenducted on 6/3/2 to Nurse #1 that Rexperiencing pain. should have imme NP and reported the reported she was a happened on 6/3/2. The Administrator Jeopardy on 7/21/2021 of Identify those recare likely to suffer, a result of the non-	commented Resident #94 had a placement performed on that fracture. conducted with the MD on AM. The MD reported that his an on-call triage line where a 24 hours a day to answer and provide orders. The MD acility had not contacted the nything related to Resident #94 2023. The MD reported that for a fractured large bone d in many complications for rsing (DON) was interviewed 21 PM. The DON explained that Resident #94 had not anyone until 6/5/2023 when er. The DON reported she was hysical therapy assessment 2023 and that PT #1 reported esident #94 had a fall and was The DON explained staff diately contacted the on-call ne fall and pain. The DON not certain why this had not 2023. Was notified of Immediate 2023 at 6:42 PM. cipients who have suffered, or a serious adverse outcome as	F 580	Beginning on Monday 8/14/2023, Aud will be conducted by the Director of Nursing, Unit Managers, and/or desig five (5) times weekly during Morning Clinical Meeting and 1 time weekly or weekend by the weekend supervisor period of four (4) weeks, then three (3 times weekly and 1 time weekly on the weekend by the weekend supervisor period of four (4) weeks, then one (1) weekly and 1 time weekly on the weekly and 1 time weekly on the weekly the weekend supervisor for a periof four (4) weeks or until 100% compliant is achieved and maintained. The Administrator and/or designee wireview these audits for compliance or weekly basis. The DON and/or designee will bring results of audits to monthly QAPI meet for review with the interdisciplinary ter (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 10 compliance.	inthe for a B) e for a time kend od of nce etting am

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING	FINI/	C 07/28/202<u>3</u>
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		515 L	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE ICORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RR 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 580	she had fallen in he On 6/3/23, the phy revealed that Resid physical therapist ther room and had facility staff. The phat the resident cothis was reported to reported that she worder for an x-ray. On 7/21/23, the Din Nurse #1, and she Resident #94 reporting to her that addition, Nurse #1 requested pain me symptoms of pain and On, 7/20/23, the The physical therapist the she reported that February that she had fatto go to the bathroor reported that the roresident had fallen On 6/5/23, after the that Resident #94 Director of Nursing interview and Resident while attemphad gotten herself reported this to the	recial Therapist on 6/3/23 that er room on 6/2/23. sical therapy evaluation dent #94 reported to the hat she had fallen on 6/2/23 in not reported the incident to the hysical therapist also reported omplained of right hip pain, and to the Nurse #1 on the hall who would follow up and obtain an rector of Nursing spoke to denied any knowledge of thing that she had fallen or that sist or any other staff member at Resident #94 had fallen. In was asked if Resident #94 dication or had signs or and Nurse #1 reported no. The reported to the hat was working on 6/3/23 and Resident #94 had reported to llen on 6/2/23 while attempting from the previous day (6/2/23). The Nurse Practitioner reported reported a fall on 6/2/23, the completed a follow up dent #94 reported that she had ting to go to the bathroom and up off the floor and had not	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130 NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/28/2023	
		515 L	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE ICORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 580	who reported that or reported to him that the bathroom and the pain. The family mereported that Resid charge nurse. On 6/5/23, during the assessment, Resid fallen on 6/2/23 in the goto the bathroom On 7/17/23, the fact Director of Nursing Practitioner was infon 6/2/23 during the by the resident. In medical record revenursing assessment physician/physician/documentation by the 6/2/23 fall until 6/5/2. The Director of Nuron 7/21/23. The intellicensed nurses and assistants that work 6/4/23 reported that to them that she had the certified medical Director of Nursing 6/2/23, 6/3/23, and assignment sheets did not report the factors.	esident #94's family member on 6/2/23, Resident #94 had to she had fallen on the way to that she was having a lot of ember reported that he ent #94 was having pain to the ent #94 was having pain to the ent #94 reported that she had the room while attempting to and was having right hip pain. Every all the revealed that the Nurse formed of Resident #94's fall or initial assessment on 6/5/23 addition, further review of the evaled that there was no fall the documentation or extender notification the licensed nurse of the 2023. Sing completed the interviews the completed that the difference of 6/2/23, 6/3/23, and the Resident #94 did not report	F 580		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 PRD	J 5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	C 07/28/202<u>3</u>
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 580	interview with the Dir that Resident #94 dir and she did not obse excruciating pain on also reported that Resother nursing staff to therapist who worked not report that Resid Nurse #3 reported the member did not report was having pain and on 6/2/23. All current residents this deficient practice. Starting 7/21/23, the Managers and design the medical records notes, outside provious medication administrorders, and nursing residents for the last physician/ physician representatives have falls or changes in concerns have been Starting 7/21/23 the designee will complecurrent residents to einclude incident and management, medicare concerneported to the physithe last 60 days by 7 Starting 7/21/23, the	3 (Weekend Supervisor) rector of Nursing revealed d not express pain concerns erve signs or symptoms of 6/3/23 and 6/4/23. Nurse # 3 esident #94 as well as the include the physical d on 6/3/23 and 6/4/23, did ent #94 has fallen on 6/2/23. hat Resident #94's family out to her that the resident I that the resident had fallen are also at risk as a result of e. Director of Nursing/the Unit nee will complete an audit of to include review of progress her notes, incident reports, reation records, physician shift reports of all the current 60 days to ensure the extenders and resident extenders and resident be been notified of any resident ondition and identified address by 7/25/23. Director of Nursing / ete interviews of the alert ensure resident concerns to accidents, pain ation/ treatments and other ins have been identified and dician/ physician extenders in 1/25/23.	F 580		

AND DUAN OF CORRECTION INTERPRETATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE COMPI		
	ROVIDER OR SUPPLIER US HEALTH AT CONCOR	345130 RD	J 5	STREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	07/2	28/202 <u>3</u>
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	assistants, certified methousekeeping/laundry staff to ensure all resident reported concern been reported to the I the Nursing supervisor of Specify the action the process or system faired adverse outcome from when the action will be starting 7/21/23, the starting 7/21/23, the starting 7/21/23 of the facility nurses, certified nursimedication aides, diethousekeeping/laundry staff related to ensuring condition to include in management changes concern, resident care resident/families reported to the license physician and/or DON nursing supervisor. Starting 7/21/23, the starting 7/21/23, t	ed nurses, certified nursing redication aides, dietary, y, agency, new hire and property dent changes in condition or is in the last 60 days have DON, Unit Manager and/or or by 7/25/23. The entity will take to alter the lure to prevent a serious in occurring or recurring, and is complete. Staff Development ewill complete education by staff to include licenseding assistants, certified tary, therapy department, y, agency, new hire and property and experiment experiment and accidents, pain is, medication/treatment experiments and any red concerns and any red concerns have been end nurse and to the individual complete education sets to include agency, new medication include agency, new include agency include	F 580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WINGSTRE	EET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202<u>3</u>
ACCORDIUS HEALTH AT CONCORD				AKE CONCORD ROAD NE CORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 580	licensed nurse will r document in the med Starting 7/21/23, the Coordinator was man Nursing that she will that the education herequired staff membersonal roster and and housekeeping/linclude new hires, a ongoing education allowed to work untileducation. The SDC DON, Unit Manager will be responsible feducation. On 7/25/23, The Director of the membersonal roster and and housekeeping/linclude new hires, a ongoing education because of the start o	/25/23. After hours the notify the on-call provider and dical record. e Staff Development and aware by the Director of libe responsible for verifying as been completed by the pers by using the facility the nursing, dietary, therapy aundry staffing schedules to agency and prn staff and by 7/25/23. No staff will be libe they have received this cold designee which includes the set of the libe they have received they have received the libe they have received they have received the libe they have received they have receive	F 580	DEFICIENCY)	
	include occupational speech therapist, where wand print therapist reported falls to the Director of Nursing Starting 7/25/23, the educate the therapist, physical therapist, physical therapist, related to ensuring reported falls are improved falls are improved the rapy staff to include the provided falls are improved falls.	ensure that all therapists to I therapist, physical therapist, eekend therapist, new hire, port resident observed and therapy manager and the mmediately. e therapy manager will ests to include occupational herapist, speech therapist, new hire, and prn therapist resident observed and mediately reported to the hid the Director of Nursing, ude prn and new hire staff will htil they receive this education. the Administrator will be uring implementation of this			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PI	ROVIDER OR SUPPLIER	345130		EET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD				LAKE CONCORD ROAD NE NCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 580	Continued From pa	ge 17	F 580		
	immediate jeopardy non-compliance.	removal for this alleged			
	Alleged Date of IJ F	Removal: 7/26/2023			
		facility's credible allegation for removal was validated by the			
	Credible Allegation facility's Director of named resident after resident complaine 6/5/2023 and a pair. The Nurse Practition resident on 6/5/2025 for evaluation due to the previous Friday completed chart residents and that were not able to interviews were consisted that were not able to inservice education policy for staff to not and responsible paralso included the nuther resident would with all resident fall education all staff (therapy, dietary, and when they are ories interviewed to ensure education. The fact assessment of the monitoring of all residents and staff (with residents and staff).	nentation to support the for F580 was reviewed. The Nursing (DON) evaluated the er she was notified the d of pain due to a fall on assessment was completed. One assessment was completed with all cognitively of a family members of residents on the action of a family members of residents. One as the action of a family members of resident of the action of the a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		J 51	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE ONCORD, NC 28025	C 07/28/202<u>3</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 580	The facility's date of the removal plan of 7/26/27/27/2023.	ne immediate jeopardy 2023 was validated on	F 580		
F 584 SS=E	CFR(s): 483.10(i)(1)-(§483.10(i) Safe Environce The resident has a right comfortable and home but not limited to recesupports for daily living. The facility must proving \$483.10(i)(1) A safe, of homelike environmentuse his or her personate possible. (i) This includes ensure receive care and serve physical layout of the independence and do (ii) The facility shall extend the protection of the receive the protection of the receive the protection of the receive services necessary to and comfortable interiors. §483.10(i)(3) Clean being good condition; §483.10(i)(4) Private of resident room, as specific speci	comment. In to a safe, clean, elike environment, including iving treatment and g safely. Ide- clean, comfortable, and t, allowing the resident to all belongings to the extent ring that the resident can ices safely and that the facility maximizes resident es not pose a safety risk. Idercise reasonable care for resident's property from loss reping and maintenance maintain a sanitary, orderly, or; ed and bath linens that are	F 584		8/26/23

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		345130	B. WING	/	C 07/28/2023	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 -	
			, 5	15 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONC	DRD	С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 584	Continued From pag	ge 19	F 584			
	levels. Facilities initi	ortable and safe temperature ally certified after October 1, a temperature range of 71 to				
	sound levels. This REQUIREMEN	e maintenance of comfortable				
	the facility failed to r grounds clean, free trash and repair bro	ons, and interviews with staff, naintain the exterior facility of broken equipment and ken floor tiles in the kitchen. If for one to nine months.		F584 Dumpster #1 lid was closed on 7/12/23 the Maintenance Director. The multiple boards of sheet rock, broke shower chair, four cement stairs, black		
	The findings include	d:		leather chair, used surgical mask, four particle board headboards, used glove, two recliner chairs, three empty cardboards.	ard	
	exterior facility ground dumpsters. One dur filled with cardboard storage. The second was closed with roo following broken iter the ground or propp " Multiple boards against the facility. " One broken sho ground.	2 PM, an observation of the ends revealed two commercial enpster was open without a lid, and no room for additional discommercial dumpster's lid enfor additional storage. The ensigned stored on ed against the facility: of sheet rock, propped entower chair stored on the entry airs stored on the ground.		boxes that were stored on the ground of propped against the facility were discarded by the Maintenance staff on 7/12/23. The broken and missing tiles in the dish pit area were replaced on 8/21/23 by the Maintenance Staff. The current residents have the potential be impacted by this deficient practice. A audit of the facility grounds to include areas with tile will be completed by 8/25/23 to ensure items are not propped against the facility, stored on the grounds.	e I to An	
	" Five wooden paground. " One black leath on the ground. " One used surginground. " Four particle books.	allets, broken, stored on the er chair, broken and stored cal face mask, stored on the eard headboards and propped against the facility		and tile is being repaired or replaced if needed. The Maintenance Director and maintenance staff will be educated by the Administrator by 8/25/26 related to ensuring that items are not propped against the facility, stored on the ground and tile is being repaired or replaced if needed.	ne	

Facility ID: 953050

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PI	ROVIDER OR SUPPLIER	345130	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
				5 LAKE CONCORD ROAD NE	
ACCORDIUS HEALTH AT CONCORD				ONCORD, NC 28025	
	CLIMANA DV	CTATEMENT OF DEFICIENCIES			N 0/5
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 584	Continued From pa	age 20	F 584		
F 584	" One used glove" Two recliner of ground next to the " Three empty of ground. An interview with the occurred on 7/19/2 Maintenance Direct November 2022, a months for the brolepicked up by the westated that the cerroutside since the pestairs were used to facility used in the placed the broken facility's van outside stated that all the coutside a few week in the process of medumpsters to be enthe commercial durevery two weeks, it several weeks now company to empty Director stated her left on the ground at the tomaintain the ground at the definition of the different stated her several weeks now company to empty Director stated her left on the ground at the different stated her several weeks now company to empty Director stated her left on the ground at the ground at the different stated her left on the ground at the different stated her left on the ground at the different stated her left on the ground at the ground at the different stated her left on the ground at the g	re, laying on the ground. hairs, broken, stored on the open commercial dumpster. eardboard boxes, stored on the	F 584	Maintenance staff will not be allowed work until the education is completed New hire maintenance staff will be required to complete the education. The Maintenance staff will complete facility rounds weekly for 12 weeks to ensure that items are not propped ag the facility, stored on the ground, and is being repaired or replaced if needed. The Administrator will submit the findit to the Quality Assurance Program Interdisciplinary (QAPI) committee meeting monthly for 3 months for reviand follow up with recommendations ensure the facility's continued complisions.	ainst tile d. ngs
	dumpster. He state undergoing renova	aced in the commercial ad that the facility was currently tions and so they secured a			

Facility ID: 953050

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED		
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WINGSTR	EET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD				LAKE CONCORD ROAD NE NCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 584	that emptying the con a schedule. He scompany emptied twill, and that the fact the dumpsters to be items could be place removal. 2. An observation of 11:28 AM revealed floor tiles in the dish the floor. A second observation of 7/19/23 at 1:10 PM During an interview Dietary Manager (Edish pit area had be since piping was read the floor where the staff mopped this at the floor where the staff mopped this at the floor tiles were underneath the kits summer of 2022, witchen. He stated in while and he just now ecould get in the	ommercial dumpster was not stated that the waste removal he commercial dumpsters at cility was currently waiting for e emptied so that the broken ed in the dumpster for If the kitchen on 7/17/23 at multiple broken and missing in pit area with water pooling on on of the same occurred on on 7/19/23 at 1:10 PM the own broken/missing for a while, placed in the kitchen last year. as a result, water pooled on tiles were broken/missing and rea daily, but water still pooled on tiles in the was aware of the or tiles in the kitchen. He stated in disrepair since piping then floor was repaired in the hen the facility had a mobile repairs to the piping took a seeded to identify a time when kitchen and repair the broken e missing tiles when there was	F 584		
		tated in an interview on that the piping underneath the			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		1 5	STREET ADDRESS, CITY, STATE, ZIP CODE S15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 584	and as a result a few	e 22 aired in the summer of 2022 floor tiles still needed repair. rected these repairs to be	F 584		
F 600 SS=J	Exploitation The resident has the neglect, misappropria and exploitation as do includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facility §483.12(a)(1) Not us physical abuse, corporation in the second of the secon	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced iews, and resident, family erapist (PT) #1, Nurse tor of Rehab Services, staff interviews, the facility a resident from the right to ion of goods and services gement and initiating medical fter a fall on 6/2/2023 for 1 of	F 600	The facility failed to notify the physiciar Resident #94 changes in condition relato an unwitnessed fall on 6/2/23 until 6/5/23 which resulted in a delay of provision of necessary medical care, treatment and services for a right hip fracture. All current residents are at risk for this deficient practice. Social Services completed interviews of the alert and interviewable residents to ensure that any concerns related to resident abuse/neglect have been identified and addressed on 7/25/23.	ted

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING	_EINI/	C 07/28/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	~ I —
ACCORDI	US HEALTH AT CONCOR	PD.	l 5	15 LAKE CONCORD ROAD NE	
ACCONDI	DO TILALITI AT CONCO	(D	0	CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 600	Continued From page	÷ 23	F 600		
	neck fracture (type of	hip fracture of the thigh		Skin assessments were completed on	
	bone). Resident #94	was sent to the hospital on		7/25/23 by the Unit Managers on all the	e
	6/6/2023 and had a p	artial hip replacement		current residents to identify any bruisin	g,
	surgery on 6/7/2023.			redness, or swelling that has not been	
				reported or that might require further	
		y began on 6/3/2023 when		investigation.	
		d right hip pain after a fall		On 7/24/23, the Activities Director mee	t
	and was not assesse	•		with the Resident Council President to	
		cal care and services were		request a short Resident Council Meeti	ing
		eopardy was removed on		to review resident rights and reporting	
	7/26/2023 when the face credible allegation of	·		Abuse/Neglect. Starting 7/21/23, the Staff Developmen	.+
		will remain out of compliance		Coordinator/ Unit Manager/ Director of	
		ty level of D (not actual		Nursing/ Nursing supervisor educated	
		al for more than minimal		facility staff to include licensed nurses,	
		ediate jeopardy) for the		certified nursing assistants (CNA),	
		aff training and to ensure		certified medication aide (CMA), dietary	у,
		ut in place are effective.		housekeeping/ laundry, therapy staff,	,
		•		maintenance, administrative staff, ager	псу
	The findings included	:		and prn staff on the abuse policy and	
				procedures to include examples of	
	Resident #94 was ad	mitted to the facility on		Abuse/neglect, abuse prevention,	
	6/2/2023 with diagnos	ses to include dementia and		reporting and identifying Abuse and	
	frequent falls.			Neglect. The staff will also be made	
				aware that all reports of Abuse and	
		g assessment recorded by		Neglect to include resident care concer	rns,
		023 at 2:03 PM documented		fall concerns, unaddressed pain, and	
		s alert and oriented to		resident bruising should be reported to	
	Territoria de la companya della companya della companya de la companya della comp	Resident #94 was always		Administrator immediately 7 days a we	
		nd bladder and required a		regardless of the time of the event. The Administrator contact information will be	
	wheelchair for mobilit	and demonstrated correct		posted at each nursing station, at the ti	
	use of the call light.	and domonociated confect		clock and at the receptionist desk.	
	acc of the ball light.			The Staff Development Coordinator an	d
	A review of the admis	sion medication orders		the Director of Nursing will be responsi	
		ot include orders for pain		for ensuring all staff to include licensed	
	medication.	· 		nurses, housekeeping/ laundry, dietary	
				administrative, CNA, and CMA receive	
	An interview was con-	ducted with Resident #94 on		Abuse and Neglect education through	

Facility ID: 953050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202<u>3</u>
NAME OF PROVIDER OR SUPPLIER					
ACCORD	US HEALTH AT CONC	ORD		5 LAKE CONCORD ROAD NE	
ACCORDIUS REALITH AT CONCORD		C	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 600	Continued From pa	age 24	F 600		
F 6000	7/20/2023 at 3:30 If evening of 6/2/202 assistance to use to came to help her, so bathroom on her or fell on the floor out her right hip. Residestarted yelling for homomate (Resident #94 said to her room, picked bed. Resident #94 was put her back in bed therapist (PT #1) cand she told PT #1 stand up because told Resident #94 reported that a nurse and reported she homedication. Resident #94 in her back in bed bed, she told them denied that a nurse and reported she homedication. Resident #94 on 7/ #94 recounted the that she thought she specifically recall the explained that she on in the bathroom was wearing slipped states.	PM. Resident #94 reported the 3 she used her call light to get the bathroom, but no staff so she got up to go to the wn. Resident #94 reported she side of the bathroom and hit lent #94 explained that she nelp immediately, and her not #50) yelled for help, too. that 2 nurse aides (NAs) came do her up and put her back in a recalled her leg hurt terribly As her leg was hurting. Unable to identify the NAs who do her in the next day to see her she did not think she could she fell the night before. PT #1 she would talk to the nurse. The her right leg "hurt so bad very time staff moved her in that it hurt. Resident #94 eassessed her after the fall had not received pain ent #94 said the NP #2 came in day morning 6/5/2023 and she had fallen and was having had she fell after dinner but could not not the time. Resident #94 couldn't recall if the lights were as on her feet, and she fell posite to the bathroom door	F 600	validation by the facility employee of and nursing, housekeeping/laundry, therapy, and dietary schedules. Staincluding new hires and prn staff will be allowed to work without complete education. The education will be on after 7/25/23 to include new hires at staff. The Director of Nursing/Unit Manag will complete audits weekly for 4 we and monthly for 2 months to ensure staff reports of Abuse and Neglect to include resident care concerns, fall concerns, unaddressed pain, and rebruising be reported to the Administ immediately 7 days a week regardle the time of the event. The Administr contact information will be posted a nursing station, at the time clock and the receptionist desk. The Director of Nursing will submit to findings to the Quality Assurance Performance Improvement committs meeting monthly for 3 months for reto ensure the facilities continued compliance.	ers eeks that o esident trator ess of rator t each d at the

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 600	ladies (NAs) came an screamed in pain the reported "I screamed moved after the fall. Resident #94 reported member on 6/2/2023 #94 said her pain was they did not do anythe explained she had an hip was fractured and hospital. Resident #94 the right leg pain even her room and that it was the right leg pain even her room and that it was the right leg pain even her room and that it was the right leg pain even her room and that it was the right leg pain even her room and that it was the family member of the family member of the family member of the facility to report the facility to report the facility to report the family member of the family member reactaminophen (and reliever) and administ Resident #94. The family member response, the family not say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member reported in pain and the say anything about family member and the say anything about family m	acreamed" (for help) and "2 and got me into bed, I a entire time." Resident #94 I every time I was touched or I never got pain medication." and she had called her family a to report the fall. Resident as "10 out of 10 all the time, aing for it." Resident #94 an x-ray that showed her right as the was sent to the but reported she cried about ary time someone came into awas "horrible pain." of Resident #94 was a on 7/20/2023 at 4:19 PM. apported that Resident #94 and on 6/2/2023 to tell him that a the was having pain in her aber explained that Resident and picked her up addidn't think he needed to call and fall. The family member avisit Resident #94 on a to Nurse #1 and reported and fallen and was having pain. apported that the nurse got apported that the nurse got apported the medication to amily member explained that and y 6/4/2023 and asked apported the fall and pain to	F 600		

MAIL OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD PAID SUMMAY STATEMENT OF DEFICIENCIES SISTER ECONCORD, NO. 28025 FRETEX DEATH AT CONCORD CONCORD, NO. 28025 FROM DEFICIENCY MIST SEPPECE SECRED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION) FROM DEFICIENCY SISTER SECRED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION) FROM DEFICIENCY SISTER SECRED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION) FROM DEFICIENCY SISTER SECRED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION) FROM DEFICIENCY SISTER SECRED BY PULL REGULATORY OR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T		T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 26 mail reporting the fall on Monday, 6/5/2023. The family member explained that an x-ray wasn't ordered until Monday 6/5/2023 after NP #2 examined Resident #94. A pain assessment was ordered on 6/2/2023 to be conducted 3 times per day. A review of the medication orders for Resident #94 revealed no scheduled or as needed pain medications were prescribed for her 6/2/2023, 6/3/2023, or 6/5/2023. The medication administration or accommended for Resident #94 no 6/2/2023, of 6/5/2023. No nursing assessments related to pain after a fall were conducted on 6/2/2023. NA #3 was interviewed on 7/21/2023 at 4:49 PM. NA #3 explained she was working on day shift (7:00 AM to 3:00 PM) on 6/2/2023 when Resident #94 was admitted to the facility, and she had assisted her to the bathroom. NA #3 indicated Resident #94 was able to transfer to the wheelchair and to the toilet by standing and pivoting to sit and the resident had no issues with the transfers or any episodes of incontinence on 6/2/2023. The pain assessment for the afternoon shift on 6/2/2023, 6/3/2023, 6/4/2023, and 6/5/2023 was recorded by Nurse #2 and she documented a pain level of *00.** (-0.10 with 10 being the most)				s 5	15 LAKE CONCORD ROAD NE	
mail reporting the fall on Monday, 6/5/2023. The family member explained that an x-ray wasn't ordered until Monday 6/6/2023 after NP #2 examined Resident #94. A pain assessment was ordered on 6/2/2023 to be conducted 3 times per day. A review of the medication orders for Resident #94 revealed no scheduled or as needed pain medications were prescribed for her 6/2/2023, 6/3/2023, 6/4/2023, or 6/5/2023. The medication administration record for June 2023 was reviewed. No administration of acetaminophen was documented for Resident #94 on 6/2/2023, 6/3/2023, 6/4/2023, or 6/5/2023. No nursing assessments related to pain after a fall were conducted on 6/2/2023. NA #3 was interviewed on 7/21/2023 at 4:49 PM. NA #3 explained she was working on day shift (7:00 AM to 3:00 PM) on 6/2/2023 when Resident #94 was admitted to the facility, and she had assisted her to the bathroom. NA #3 indicated Resident #94 was able to transfer to the wheelchair and to the toilet by standing and pivoting to sit and the resident had no issues with the transfers or any episodes of incontinence on 6/2/2023. The pain assessment for the afternoon shift on 6/2/2023. 6/3/2023, 6/3/2023, and 6/5/2023 was recorded by Nurse #2 and she documented a pain level of *0°.* (0-10 with 10 being the most	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
An interview was conducted on 7/21/2023 at	F 600	mail reporting the fall family member explain ordered until Monday examined Resident #8 A pain assessment was be conducted 3 times. A review of the medications were present of the medications were present of the medications were present of the medication admir 2023 was reviewed. No acetaminophen was of #94 on 6/2/2023, 6/3/2023, 6/3/2023, 6/3/2023, 6/3/2023, 6/3/2023. The pain assessment of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to sit and the transfers or any endocation of the pivoting to si	on Monday, 6/5/2023. The ned that an x-ray wasn't 6/5/2023 after NP #2 94. as ordered on 6/2/2023 to per day. ation orders for Resident duled or as needed pain scribed for her 6/2/2023, r 6/5/2023. Inistration record for June to administration of locumented for Resident 2023, 6/4/2023, or 6/5/2023. Ints related to pain after a n 6/2/2023. In 6/2/2023 at 4:49 PM. was working on day shift on 6/2/2023 when Resident the facility, and she had throom. NA #3 indicated e to transfer to the toilet by standing and resident had no issues with pisodes of incontinence on for the afternoon shift on 6/4/2023, and 6/5/2023 was and she documented a 0 with 10 being the most	F 600		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WINGSTRE	EET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD				LAKE CONCORD ROAD NE ICORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 600	12:04 PM with NA a provided care to Re afternoon shift. NA experienced urinary report pain and she shift. When asked i #94 off the floor after on, she had not pic floor after a fall. Nurse #2 was interned pM and she reported Resident #94 durin 6/3, 6/4, and 6/5/20 was in pain at all to the pain assessment A follow up intervier at 1:44 PM reveale #94 was experient or 6/5/2023 during reported that no on fall or was experient indicated that wher assessment for Refollow and for Refollow and for pain. Nurse notice swelling or be leg during any of he she was aware of the work on 6/5/2023 for #2 reported she was to the physician bursent until after the edenied conducting #94, except for the Night shift (11:00 P	#7 and she reported she esident #94 on 6/2/2023 for the #7 reported Resident #94 y incontinence, but she did not e did not report a fall during her of she had assisted Resident er a fall, NA #7 reported that ked Resident #94 up off the eviewed on 7/19/2023 at 4:05 and that she was assigned to go the afternoon shift on 6/2, 123 had not expressed she her when Nurse #2 conducted	F 600		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING	
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 DRD	51	TREET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE ONCORD, NC 28025	C 07/28/202<u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
F 600	phone on 7/21/2023 explained that she de Resident #94's hallw to that hallway on 6/ Resident #94 did no performed the pain a time during the shift, a resident reported prote or addressed it. There was no evider any nurse notified the fall and subsequent assessment of Resident assessment of Resident assessment of Residered on 6/2/2023 Day shift on 6/3/2023 Day shift on 6/3/2023 Day shift on 6/3/2023 Nurse #1 document Nurse #1, an agency Resident #94 on 6/3/2023 AM to 3:00 PM). Mu Nurse #1 for an interincluding phone call text messages. NA #1 was interview NA #1 reported she #94 on 6/3/2023 and NA #1 reported Resident when they reported she had reported sh	nducted with Nurse #9 by at 11:33 AM. Nurse #9 by at 11:33 AM. Nurse #9 bid not frequently work vay (C), but she was assigned 2/2023. Nurse #9 indicated t report pain when she assessment or at any other, and Nurse #9 stated, "No, if pain, I would have written a in the pain assessment." Ince in the medical record that the physician of Resident #94's pain, completed an in the pain assessment recorded ented a pain level of "0'. If yourse, was assigned to be with the pain assessment recorded ented a pain level of "0'. If yourse, was assigned to be with the pain to contact the pain to contact the pain to Resident in the pain during the moved her in bed. NA #1 ported the pain to Nurse #1 reported Resident #94 did not y shift for 6/3/2023 or quired incontinence care in	F 600		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	DISTRUCTION	(X3) DATE SURVEY COMPLETED	
DOWNER OR OURDUIES	345130	B. WING	TET ADDRESS CITY STATE 7/D CODE	C 07/28/202 <u>3</u>	
ACCORDIUS HEALTH AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
NA #6 reported that Resident #94, but h roommate, Resident 6/3/2023. NA #6 re Resident #94 fell or NA #6 was interview 12:01 PM and he re evening shift on 6/2 and he had not pick floor on 6/2/2023 ar reported pain, he w The weekend superinterviewed by phor Nurse #3 reported s 6/4/2023 from 7:00 staff reported that F pain. A physical therapy of and dated 6/3/2023 #94 reported right h The note document notified the nurse (Uhaving pain in her right had been pain and h	he was not assigned to ad provided care to her t #50 for day shift on ported that he found out a 6/5/2023. wed again on 7/20/2023 at aported he worked day and a formal f	F 600			
	Continued From page NA #6 reported that Resident #94 fell on NA #6 was interview 12:01 PM and he reevening shift on 6/2 and he had not pick floor on 6/2/2023 arreported pain, he we The weekend super interviewed by phor Nurse #3 reported shift on 6/2 and he had not pick floor on 6/2/2023 arreported pain, he we The weekend super interviewed by phor Nurse #3 reported shift on 6/2 and he had not pick floor on 6/2/2023 arreported pain, he we The weekend super interviewed by phor Nurse #3 reported shift on 6/2 and dated 6/3/2023 from 7:00 staff reported that Repain. A physical therapy eand dated 6/3/2023 from 7:00 staff reported right had the nurse (uhaving pain in her riped the nurse (uhaving pain in her riped years). PT #1 was interview 2:49 PM. PT#1 reported years and he had her that Resident #94 and he told her that Reside Resident #94 and he told her that Reside	ROVIDER OR SUPPLIER US HEALTH AT CONCORD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 NA #6 reported that he was not assigned to Resident #94, but had provided care to her roommate, Resident #50 for day shift on 6/3/2023. NA #6 reported that he found out Resident #94 fell on 6/5/2023. NA #6 was interviewed again on 7/20/2023 at 12:01 PM and he reported he worked day and evening shift on 6/2/2023, 6/3/2023 and 6/4/2023 and he had not picked up Resident #94 from the floor on 6/2/2023 and if Resident #94 had reported pain, he would have reported the pain. The weekend supervisor Nurse #3 was interviewed by phone on 7/20/2023 at 1:39 PM. Nurse #3 reported she worked 6/3/2023 and 6/4/2023 from 7:00 AM until 11:00 PM and no staff reported that Resident #94 was experiencing pain. A physical therapy evaluation performed by PT #1 and dated 6/3/2023 documented that Resident #94 reported right hip pain from a fall 6/2/2023. The note documented the physical therapist notified the nurse (unnamed) Resident #94 was having pain in her right hip. PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #94 on 6/3/2023 and she attempted to stand Resident #94 at the bedside, but Resident #94 was unable to stand. The PT explained that Resident #94 was unable to stand. The PT explained that Resident #94 are hor roommate, Resident #94 was unable to stand during the evaluation without moderate assistance and	ROVIDER OR SUPPLIER 345130 B. WING STRE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 NA #6 reported that he was not assigned to Resident #94, but had provided care to her roommate, Resident #50 for day shift on 6/3/2023. NA #6 reported that he found out Resident #94 fell on 6/5/2023. NA #6 was interviewed again on 7/20/2023 at 12:01 PM and he reported he worked day and evening shift on 6/2/2023, 6/3/2023 and 6/4/2023 and he had not picked up Resident #94 from the floor on 6/2/2023 and if Resident #94 had reported pain, he would have reported the pain. The weekend supervisor Nurse #3 was interviewed by phone on 7/20/2023 at 1:39 PM. Nurse #3 reported she worked 6/3/2023 and 6/4/2023 from 7:00 AM until 11:00 PM and no staff reported that Resident #94 was experiencing pain. A physical therapy evaluation performed by PT #1 and dated 6/3/2023 documented that Resident #94 reported right hip pain from a fall 6/2/2023. The note documented the physical therapist notified the nurse (unnamed) Resident #94 was having pain in her right hip. PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #94 on 6/3/2023 and she attempted to stand Resident #94 at the bedside, but Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #50, told her that Resident #94 was unable to stand during	A BUILDING 345130 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE \$15 LAKE CONCORD NC 28025 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL RESULATIONY OR LSO (DENTIFYING INFORMATION) COntinued From page 29 NA #6 reported that he was not assigned to Resident #94, but had provided care to her roommate, Resident #50 for day shift on 6/3/2023. NA #6 reported that he found out Resident #94 fell on 6/5/2023. NA #6 was interviewed again on 7/20/2023 at 12:01 PM and he reported he worked day and evening shift on 6/2/2023, 6/3/2023 and 6/4/2023 and he had not picked up Resident #94 from the floor on 6/2/2023 and if Resident #94 had reported by home on 7/20/2023 at 1:39 PM. Nurse #3 reported she worked 6/3/2023 and 6/4/2023 from 7:00 AM until 11:00 PM and no staff reported that Resident #94 was experiencing pain. A physical therapy evaluation performed by PT #1 and dated 6/3/2023 documented that Resident #94 was having pain in her right hip. PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #94 and her roommate, Resident #94 and her roommate, Resident #94 and her roommate, Resident #94 was having pain in her right hip. PT #1 was interviewed by phone on 7/21/2023 at 2:49 PM. PT#1 reported she evaluated Resident #84 at the bedside, but Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #94 was unable to stand Resident #94 and her roommate, Resident #94 was unable to stand. The PT explained that Resident #94 and her roommate, Resident #94 reported right hip pain to her with touch. Resident #94 was unable to stand during the evaluation without moderate assistance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING	/ \	C 07/28/2023	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			515	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE NCORD, NC 28025	011201202	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	#94 was experience unknown nurse and order for an x-ray for certain the time of a #94. PT #1 was unthe nurse or the time. The Director of Ref 7/25/2023 at 8:59 A Rehabilitation repowork on 6/3/2023 at 8:59 A Interfered or limited documented that R interfered or limited location) and that management. The Resident #94 report and she had pain in The Occupational Tinterviewed on 7/25 OT #1 reported she on 6/3/2023 and Refallen on 6/2/2023. Not report to the nutold her that the NA off the floor. OT #1 did not have pain dhad not gotten Reside afternoon shift. The #94 complained of	Il and the pain that Resident ing. PT #1 reported an id told her she would get an or Resident #94. PT#1 was not day she evaluated Resident able to provide the name of the she reported to the nurse. Inabilitation was interviewed on the she reported to the nurse of the she reported to the nurse. Inabilitation was interviewed on the she reported to the nurse of the she reported to the nurse. Inabilitation was interviewed on the she provided in to the she she and a fall on 6/2/2023	F 600			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCOL	345130 RD	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 600	received the report for the two of them talking to get out of bed during 6/3/2023 because of with moving. NA #2 rebruising on Resident There was no evident any nurse notified the fall and subsequent passessment of Reside ordered on 6/3/2023. The pain assessment was recorded by Nurse #8 was intervite at 1:53 PM and she received Resident #94 during reported Resident #94 was in pain at all to he the pain assessment reported she remember requesting a on 6/4/2023. Nurse #8 report fall to her. The pain assessment and 6/4/2023 were resulted to the resulted for the pain assessment and 6/4/2023 were resulted for the	ain a nurse. NA #2 remember the nurse that om PT #1, but she had seen g. Resident #94 was unable ng the afternoon shift on the pain she experienced eported she did not notice #94's right hip. the in the medical record that the physician of Resident #94's rain, completed an tent #94, or that an x-ray was after day shift on 6/4/2023 the was assigned to the day shift on 6/4/2023 and the had not expressed she there when Nurse #8 conducted to 6/4/2023. Nurse #8 there Resident #94's family walker during the day shift the reported she recalled that the physician of Resident #94's the resident #94's family walker during the day shift the reported she recalled that the physician of Resident #94's the recalled that the physician of Resident #94's the recalled that the physician of Resident #94 the physician of Re	F6			

C 07/28/202 <u>3</u> (X5) COMPLETION DATE
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COMPLETION

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	ROVIDER OR SUPPLIER US HEALTH AT CON	345130 CORD	515	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE NCORD, NC 28025	C 07/28/202 <u>3</u>
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F 600	the day shift, and care, Resident #9 leg!" NA #3 reporday shift Resident incontinence brief care. NA #3 explain and when they rein NP #2 was at the Resident #94 was yelling out in pain #94 experienced had to get anothe incontinence care her pain level. Nother pain was in he and severe with a turning for incontinence care with a turning for incontinence care and had a severe with a turning for incontinence care. A progress note with documented Resi 6/2/2023 she atte and had a fall with fall). The NP doc increased pain/dis was noted, and the right hip/thigh and described as Resident #94 had this time, and staf Resident #94 until NP #2 was intervi	assigned to Resident #94 on when she attempted to provide 4 yelled in pain "my leg, my ted on Monday 6/5/2023 for the target #94 was in bed with an 5 on and required incontinence ined she went to get Nurse #6, turned to Resident #94's room, bedside. NA #3 described that a unable to move in bed without and NA #3 explained that Resident pain all day on 6/5/2023 and she ar NA to assist her with for Resident #94 because of A #3 reported Resident #94 said for right hip and it was very sharp my kind of movement and mence care was unbearably ported on 6/2/2023 Resident et up to the bathroom, but she day 6/5/2023 and received	F 600		

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		345130	B. WING	EINI/	C 07/28/2023	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			515 L	ET ADDRESS, CITY, STATE, ZIP CODE AKE CONCORD ROAD NE CORD, NC 28025	-\ L	
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F 600	6/5/2023 when Repain and fall. NP #x-ray of Resident #was read and it was had a fracture, she evaluation. An interview was con 7/25/2023 at 11 provided Resident 6/5/2023 during the #94 was in intense she attempted to pherself, and this cand scream" in pain had to get another #4 reported she to was in pain. A hip x-ray dated 6 read a right subcard displacement (acural A nursing note date documented the received by the fact The on-call NP was received an order thospital for evalua The note documented facility by ambulan There was no evid pain medication was	nent on Resident #94 on sident #94 reported the hip #2 explained she ordered an #94's hip and when the x-ray is determined Resident #94 was sent to the hospital for onducted with NA #4 by phone :10 AM. NA #4 reported she #94 with incontinence care on a afternoon shift and Resident pain all shift. NA #4 reported rovide incontinence care by sused Resident #94 to "scream in. NA #4 explained that she NA to assist her with care. NA id Nurse #2 that Resident #94 1/5/2023 and read at 9:39 PM oital fracture with moderate the right hip fracture). 1/6/6/2023 at 12:31 AM issults of the hip x-ray were stillity at 11:45 PM on 6/5/2023. Is paged, and the nurse to send Resident #94 to the tion for the right hip fracture. Ited that Resident #94 left the	F 600			
	dated 6/6/2023 at	partment (ED) provider note 1:28 AM documented Resident right hip pain that was found				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED		
NAME OF PI	ROVIDER OR SUPPLIER	345130		EET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD				ICORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 600	earlier that day. Re three days ago and since. The note doo by the facility shows exam the ED physic right hip without def obtained confirmed femoral neck fractur or documentation or pain. Orthopedic su 3:05 AM recommen admitted and make status. An orthopedic traun 6/6/2023 at 10:40 A (Resident #94) repowas attempting to glanding on her right pain in the right hip after the fall. The his "Right lower extrem (redness). Leg leng contralateral leg (lef rotation (leg was rot (agreed) hip pain with the floor during massessment and planeck fracture was dand the recommench hip hemiarthroplasty plan was also discu who agreed and stacompetent to sign hem and the recommench of the floor during massessment and planeck fracture was dand the recommench planeck fracture was dan	n x-ray obtained outpatient sident #94 reported she fell has had right hip pain ever umented the x-ray obtained ed a right hip fracture. On sian noted tenderness to the ormity. Repeat x-rays a closed subcapital right re. There was no pain rating, f medications administered for regery was consulted and at ded for Resident #94 to be her NPO (nothing by mouth) The aconsult note dated M documented: Patient orted on Friday 6/2/2023 she et up to the bathroom and fell, hip. She reported immediate and being unable to get up story and physical noted: ity: skin intact without the short in comparison to it leg) and hip held in external stated to the right). Endorses ith heel strike (touching heel hobility)." Details in the an included the right femoral iscussed with Resident #94 dation was to proceed with the ry, to which she agreed. This seed with a family member ted Resident #94 was er own consents.	F 600		
		umented Resident #94 had a accement performed on that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130 NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		515 L	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE ICORD, NC 28025	C 07/28/202 <u>3</u>	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 600	7/21/2023 at 11:54 medical group has NP is available 24 questions and provided triage for anything 6/2/2023, 6/3/2023 MD reported that diffractured large bon complications for Reported large bon to aware she did medication. The Director of Nuron 7/21/2023 at 3:2 that she had though reported the fall to NP #2 assessed he not aware of the producted on 6/3/2 to an unknown nurand was experience interviewed Resided NP evaluation and had fallen and gotted did not report the fastaff should have ir on-call NP and representations assessed Resident was not certain whe 6/3/2023.	fracture. onducted with the MD on AM. The MD reported that his an on-call triage line where a hours a day to answer medical ride orders. The MD reported not contacted the on-call related to Resident #94, 6/4/2023 or 6/5/2023. The elaying treatment for a re could have resulted in many resident #94 and would have or Resident #94, and he was not have an order for pain rsing (DON) was interviewed 21 PM. The DON explained the Resident #94 had not anyone until 6/5/2023 when for. The DON reported she was resident #94 had a fall ring pain. The DON stated she ent #94 on 6/5/2023 after the Resident #94 reported she ent #94 on 6/5/2023 after the Resident #94 reported she ent herself up off the floor and fall to staff. The DON explained mediately contacted the orted the fall and pain and the #94. The DON reported she by this had not happened on was notified of Immediate	F 600		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 DRD	J 515	REET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE NCORD, NC 28025	C 07/28/202 <u>3</u>	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	are likely to suffer, a a result of the noncomment of the facility failed to free from neglect. The facility failed to resident changes in unwitnessed fall on resulted in a delay of medical care, treatment in fracture. The fact pain from 6/2/23 to 6/2/23 to 6/3/23 to 6/5/23. Resident from facility failed to follow up or resulting in resident documentation of patto the resident from facility failed to compassessments on 6/2 ensure preventative. There was no evident staff interviews that assessment of the resident from facility failed to compassessment of the result in the resident from facility failed to compassessment of the resident from facility failed to follow the failed from	pients who have suffered, or serious adverse outcome as impliance ensure that Resident #94 was notify the physician of condition related to an 6/2/23 until 6/5/23 which f provision of necessary ent, and services for a right ility failed to address resident 6/5/23 that would be of fracture. The facility staff in resident reported pain unaddressed pain from eview of Resident #94's ration revealed no in medication being provided 6/2/23 through 6/6/23. The oldete all the facility admission 1/23 for a new admission to measures are in place. Ince from record review and increasing staff completed an esident after the fall on 6/2/23 by the Nurse Practitioner on interest attends where the fall on 6/2/23 to Nurse #2 on nied knowledge of the fall on call therapy evaluation	F 600			
	physical therapist th	ent #94 reported to the at she had fallen on 6/2/23 in of reported the incident to the				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CON	345130 CORD	515	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE NCORD, NC 28025	C 07/28/202 <u>3</u>
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F 600	that the resident of this was reported reported that she order for an x-ray. Review of the med #1 did not comple the fall and did not assessment of Resolution of the properties of the propert	hysical therapist also reported omplained of right hip pain, and to the Nurse #1 on the hall who would follow up and obtain an dical record revealed that Nurse the any documentation related to a complete a nursing sident #94. The Nurse Practitioner initial ent #94 reported that she had her room while attempting to an and was having right hip pain. Oner assessed the resident and fort to the right hip area, but no did. The Nurse Practitioner also he right hip and reported that it hip was dislocated. New orders given to the nursing staff and to to the emergency room if x ray acture. Int #94 reported to the Director to had fallen while attempting to an and had gotten herself up off not reported this to the staff on the thip x-ray was obtained. Spm, the licensed nurse results which revealed an exture.	F 600		
		emergency room by portation per stretcher for			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	J 5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.475
F 600	hospital and a right hiperformed on 6/7/23. On 7/20/23, the 3-11 Staff Development Correction Resident #94 and she females came into he and put her back in bresident #94 reporter remember who they was All the current resident this deficient practice. Starting 7/21/23, Socialert and interviewable any concerns related have been identified a Starting 7/21/23 a ski completed by the Unicurrent residents to it or swelling that has might require further. On 7/24/23, the Activithe Resident Council Merights and reporting All or Specify the action the process or system fair adverse outcome from when the action will be Starting 7/21/23, the	anursing supervisor and the coordinator interviewed be reported that two black for room and picked her up led after the fall on 6/2/23. It is a real trisk as a result of learning and the resident abuse/neglect and addressed by 7/25/23. In assessment will be the Managers on all the lentify any bruising, redness, of been reported or that investigation by 7/25/23. It is Director will meet with President to request a short letting to review resident libuse/Neglect. The entity will take to alter the lure to prevent a serious in occurring or recurring, and the complete.	F 600		

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PI	ROVIDER OR SUPPLIER	345130	B. WINGSTR	EET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD				LAKE CONCORD ROAD NE NCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 600	include licensed nur assistants (CNA), ce (CMA), dietary, hous staff, maintenance, and prn staff on the to include examples prevention, reporting Neglect. The staff we reports of Abuse and care concerns, fall ce and resident bruising Administrator immediates of the time Administrator contact	will educate facility staff to ses, certified nursing ertified medication aide sekeeping/ laundry, therapy administrative staff, agency abuse policy and procedures of Abuse/neglect, abuse g and identifying Abuse and ill also be made aware that all d Neglect to include resident oncerns, unaddressed pain, g should be reported to the diately 7 days a week	F 600		
	Director of Nursing vensuring all staff to housekeeping/ laund CNA, and CMA rece education through vemployee roster and housekeeping/laund schedules. Staff incivill not be allowed to education. The education. The education. The education of the complete for ensummediate jeopardy non-compliance. Alleged Date of IJ Received.	ry, therapy, and dietary uding new hires and prn staff to work without completing this eation will be ongoing after ew hires and prn staff. e Administrator will be uring implementation of this removal for this alleged			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCOR	345130 RD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		28/202 <u>3</u>
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	following: The facility provided of their credible allegation. The nare by the Nurse Practition the hospital for evaluation of their esidents fall. The facility also had a review all residents for each The facility also had a review all residents integration of their esidents for each The facility also had a review all residents in neglect. The facility paudits of resident inteassessments to ensurabuse and neglect. A housekeeping, maintonursing) received an regarding abuse, negrous abuse, negrous abuse, negrous abuse, negrous abuse, negrous disciplines revealed upin-service provided for facility further provided provided to all facility agency staff before the facility. The facility assessments and interesidents, and educated by 7/25/2023. The facility's date of the state of the facility of the facili	documentation to support on for Abuse, Neglect and med resident was assessed oner on 6/5/2023 and sent to ation of pain from a fall 3. The facility also provided ir investigation of the cility interviewed all alert and garding any issues regarding and completed skin in resident by 7/25/2023. A resident council meeting to ights regarding abuse and provided documentation of erviews and skin re continued monitoring for All staff (dietary, genance, therapy, and in-service education lect, and exploitation by of staff across these	F 600			
F 655 SS=D	Baseline Care Plan		F 655	5		8/26/23

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPARTMENT OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCOL	345130 RD	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	C 07/28/202 <u>3</u>
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.475
F 655	Planning §483.21(a) Baseline §483.21(a)(1) The faci implement a baseline that includes the instreffective and personthat meet professional The baseline care platiciliant (i) Be developed with admission. (ii) Include the minimular necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommulations (F) PASARR recommulations (F) PASARR recommulations (II) Meets the requirer (b) of this section). §483.21(a)(3) The factorial forms (PASAS (PASAS) (cive Person-Centered Care Care Plans cility must develop and care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's care for a resident ted to- I on admission orders. cility may develop a colan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary clan that includes but is not	F 655		

Facility ID: 953050

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	X3) DATE SURVEY COMPLETED	
NAME OF PI	ROVIDER OR SUPPLIER	345130	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>	
ACCORDIUS HEALTH AT CONCORD		ORD		15 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 655	on behalf of the fact (iv) Any updated into of the comprehension of the	and treatments to be a facility and personnel acting ility. Formation based on the details we care plan, as necessary. Formation based on the details we care plan, as necessary. Formation based on the details we care plan, as necessary. Formation based on the details we care plan admission that addressed the with a history of frequent falls as reviewed for baseline care. For ed: Formation based on the details we care plan admission that addressed the with a history of frequent falls as reviewed for baseline care. For ed: For ed: For Resident #94 included admitted to the facility on the place for Resident #94 or 6/5/2023. For ed: For	F 655	PROBLEM IDENTIFIED: During Annual & Complaint Survey with exit date July 28, 2023, deficient practice was cited. Based on record reviews and staff interview, the facility failed to develop a baseline care plan within 48 hours of admission that addressed the needs of resident with a history of frequent falls for 1 of 29 residents reviewed for baseline care plans (Resident #94). ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENT(S) FOUND TO HAVE BEEN AFFECTED: Resident #94 s care plan was initiated 6/6/23 by the MDS coordinator. Resident #94 baseline care plan assessment/UDA was completed on 7/2/23. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME ISSU	a or N I on	
	#94 was readmitted			RESIDENTS HAVING THE POTENTIAL		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 07/28/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	- A III
				515 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CON	CORD		CONCORD, NC 28025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 655	Continued From page	age 44	F 655		
	7/2/2023.			All residents have the potential to be	
				affected by the same issue.	
		conducted with Nurse #6 on			
		PM. Nurse #6 reported she		The Director of Nursing, Unit Manager(
		#94 from home on 6/2/2023		and/or designee will complete an audit	
		:00 PM when Resident #94		or before Wednesday August 16, 2023	
		ty. Nurse #6 reported she had		residents currently residing in the facilit	-
		seline care plan for Resident nad arrived late in her shift		who were admitted within the last 60 days to ensure that a Baseline Care Plan	ays
	(7:00 AM to 3:00 F			assessment/UDA was completed within	
	(7.00 7 11 10 0.00 1	,.		48 hours of admission.	·
	Nurse #2 was inter	rviewed on 7/19/2023 at 4:05		10 110 410 01 4411110010111	
	PM and she report	ed she was assigned to		Residents without a Baseline Care Plan	n
	Resident #94 on 6	/2/2023, 6/3/2023, 6/4/2023,		assessment/UDA within 48 hours or	
		ng the afternoon shift (3:00 PM		admission will have a Baseline Care Pl	
	· '	se #2 reported she was not		assessment/UDA completed on/before	
		care plan had not been initiated		Wednesday August 16, 2023. The wer	
	on admission for R	Resident #94.		no additional current residents identifie	d in
	A = :=4= = := :	and rated with the MDC numer		the initial audit without a baseline care	
		conducted with the MDS nurse 44 PM. The MDS nurse		plan completed in 48 hours of admission	on.
		ssion nurse should initiate the		ADDRESS WHAT MEASURES WILL E	RE
	baseline care plan			PUT IN PLACE OR SYSTEMIC	, <u> </u>
	bassiii sars pian	on daniesion.		CHANGES MADE TO SURE THAT TH	E
	The Unit Manager	Nurse #5 was interviewed on		IDENTIFIED ISSUE DOES NOT OCCU	
		3 AM. Nurse #5 reported the		IN THE FUTURE:	
	interdisciplinary tea	am discusses new admissions			
		eting, but because Resident		Starting on Monday August 14, 2023, t	he
		on a Friday afternoon, they did		Director of Nursing will educate Unit	
		til Monday 6/5/2023. Nurse #5		Managers, Staff Development Coordinate	<u> </u>
		ity had just learned Resident		(SDC) and Nursing Supervisors regard	ing
		023 and the team was focusing		completing a resident □s baseline care	
	baseline care plan	tment and did not address the		plan assessment/UDA promptly upon admission and ensuring completion wit	hin
	paseinie care plan	•		the first 48 hours of admission and their	
	An interview was o	conducted at the same time		responsibility to verify timely completion	
		f Nursing (DON) and she		on the next working day following resid	<u> </u>
		e care plan should have been		admission and address	
		nission nurse or the nurse after		identified/incomplete baseline care plan	n

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCOR	345130 RD	5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	07/2	28/202 <u>3</u>
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	had not been started reported she expected	ain why a baseline care plan for Resident #94. The DON d all new admissions to plan in place within 24 hours	F 655	assessment/UDAs promptly. Education will be complete on or before Wednesday August 16, 2023. Starting on Monday August 14, 2023, tl Staff Development Coordinator (SDC), Director of Nursing, and/or designee with complete education with licensed nurse including agency and PRN nurses, regarding completing a resident shaseline care plan assessment/UDA promptly upon admission, and ensuring completion within the first 48 hours of admission. Education will be completed on or before Wednesday August 16, 2023. Licensed nurses will not be permitted to the appropriate education regarding baseline care plans being completed in timely manner. Education will be ongoing with newly his licensed nurses and agency nurses. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT THE SOLUTIONS ARE SUSTAINED. THE FACILITY MUDEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AN SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTION EVALUATED FOR ITS EFFECTIVENESS: The facility will monitor its performance	re oved a ired SO ST ND	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WING	IREET ADDRESS, CITY, STATE, ZIP CODE		C 28/202<u>3</u>
	US HEALTH AT CONCOR	RD	51	IS LAKE CONCORD ROAD NE ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	± 46	F 655	the Director of Nursing, Unit Managers, and/or designee conducted an audit of new admissions since the most recent audit to ensure that baseline care plan assessment/UDAs have been complete within 48 hours of admission and to ensure that residents at risk for falls hat this addressed appropriately in their baseline care plan assessment/UDA. Beginning on Monday 8/14/2023, Audit will be conducted by the Director of Nursing, Unit Managers, and/or designe five (5) times weekly during Morning Clinical Meeting for a period of four (4) weeks, then three (3) times weekly for a period of four (4) weeks or until 100% compliance is achieved and maintained. The weekend supervisor waudits of the weekend admissions for 1 weeks to ensure continual compliance. The Administrator and/or designee will review these audits for compliance on a weekly basis. The DON and/or designee will bring results of audits to monthly QAPI meetifor review with the interdisciplinary tear (IDT). The IDT will discuss the need for changes/continuation of this plan during monthly QAPI meetings to achieve 100 compliance.	ed ve s ee a me ill 2	
F 697 SS=J	Pain Management CFR(s): 483.25(k)		F 697	·		8/26/23

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		345130	B. WING		C 07/28/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	\
4.000 DDI	UC UEALTU AT CONO	ODD	J 5	15 LAKE CONCORD ROAD NE	
ACCORDIUS HEALTH AT CONCORD		C	CONCORD, NC 28025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 697	Continued From pa	ge 47	F 697		
	§483.25(k) Pain Ma	ınagement.			
		sure that pain management is			
		ts who require such services,			
		essional standards of practice,			
		person-centered care plan,			
		poals and preferences.			
	This REQUIREMEN	NT is not met as evidenced			
	by:				
		eviews, resident, family, nurse		On 7/23/23, Resident #94 pain	
	practitioner, physici	an, and staff interviews, the		assessment was completed by the Unit	
	facility failed to effe	ctively manage pain for a		Manager revealing a pain level of 4 with	
	resident after she e	xperienced a fall and reported		the resident expressing occasional pain.	
	pain for 1 of 5 resid	ents investigated for pain		On 6/30/23, Resident #94 pain care plan	
	management (Resid	dent #94). Resident #94		was reviewed and revised by the	
		at caused her to yell and		Minimum Data Set licensed nurse.	
	scream. The pain a	ffected her ability to go to the			
	bathroom and she b	pecame incontinent.		All the current residents are at risk as a	
				result of this deficient practice.	
		dy began on 6/3/2023 when		Starting 7/21/23, the Director of Nursing	
		ted hip pain to Physical		and Nursing Unit Manager observed and	
		nd nursing did not effectively		interviewed the current residents and	
		nmediate Jeopardy was		completed new pain assessments to	
		023 when the facility		include review of progress notes, care	
		lible allegation of Immediate		plans and resident pain regiments to	
		The facility will remain out of		ensure resident pain is being managed	
	-	ope and severity level of D (not		and/or prevented by 7/25/23. There were	;
		e potential for more than		no additional issues identified.	
		s not immediate jeopardy) for		On 7/21/23, the Chief Nursing Officer	
		ete staff training and to ensure		reviewed the Maple Health Pain	
	monitoring systems	put in place are effective.		Management Program with the Director of	וע
	The findings include	od:		Nursing to include identifying resident pain, signs and symptoms of pain, pain	
	The findings include	5 u.		assessment, reporting resident pain, pair	
	Resident #04 was a	admitted to the facility on		documentation, pain medication	1
		oses to include dementia and		management, and pain care plans.	
	frequent falls.	10000 to include defileritia and		management, and pain care plans.	
	5445/11 14115.			On 7/21/23, the Director of Nursing	
	The admission nurs	sing assessment recorded by		reviewed the Maple Health Pain	
	,	J	1	,	

Facility ID: 953050

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING		C 07/28/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				515 LAKE CONCORD ROAD NE	/
ACCORDI	US HEALTH AT CON	CORD		CONCORD, NC 28025	
	0.1111112	4.07475145147.05.D55(0)510(5)			OTION
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 697	Continued From p	age 48	F 69	7	
	Nurse #6 dated 6/ Resident #94 was and situation. Resident mobility. Resident mobility. Residence and demonstration. An interview was 67/20/2023 at 3:30 evening of 6/2/2020.	2/2023 documented that alert and oriented to person ident #94 was always continent dder and required a wheelchair ent #94 was oriented to her trated correct use of the call conducted with Resident #94 on PM. Resident #94 reported the 23 she used her call light to get the bathroom, but no staff		Management Program with the S Development Coordinator to includentifying resident pain, signs an symptoms of pain, pain assessm reporting resident pain, pain documentation, pain medication management, and pain care plan. The licensed nurses, certified nurses assistances, certified medication include agency staff, new hires, a nursing staff educated was comp	ude nd ent, as. rsing aids to and prn
	came to help her, bathroom on her of fell on the floor ou her right hip. Resistanted yelling for roommate (Resident #94 said to her room, picke bed. Resident #94 was put her back in be therapist (PT #1) of and she told PT # stand up because told Resident #94 Resident #94 report all the time" and e bed, she told them	so she got up to go to the own. Resident #94 reported she tside of the bathroom and hit dent #94 explained that she help immediately, and her ent #50) yelled for help, too. that 2 nurse aides (NAs) came d her up and put her back in 4 recalled her leg hurt terribly lAs her leg was hurting. unable to identify the NAs who d. Resident #94 explained the came in the next day to see her 1 she did not think she could she fell the night before. PT #1 she would talk to the nurse. orted her right leg "hurt so bad very time staff moved her in that it hurt. Resident #94		7/25/23 by the Staff Development Coordinator (SDC)/ Director of Northe Pain Management Program to identifying resident pain, signs as symptoms of pain, pain assessmore porting resident pain, pain documentation, pain medication management, and pain care plants staff will be allowed to work until received this education. The SDC designee which includes the DOI Managers, and Nursing supervise be responsible for providing all of education. The SDC will continuate review the daily staff assignment ensure nursing staff completes the required education. On 7/25/23, The Director of Nursing Supervision of S	t ursing on o include and ent, is. No they have C/ N, Unit ors will f the e to sheets to he
	and reported she medication. Resid to see her on Mon told the NP that shright hip pain.	e assessed her after the fall had not received pain ent #94 said the NP #2 came in day morning 6/5/2023 and she he had fallen and was having ew was conducted with		educated the therapy manager to that therapists to include occupar therapist, physical therapist, spectherapist, new hires, weekend strong report resident pain concerns therapy manager and the Director Nursing immediately. The DON is available 24/7 and contact inform	tional ech aff and s to the or of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING	/ \	C 07/28/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	A
			, 5	15 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CONC	ORD	0	CONCORD, NC 28025	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	5.475
F 697	Continued From pag	ge 49	F 697		
	Resident #94 on 7/2	21/2023 at 1:58 PM. Resident		located at each nursing state.	
	#94 recounted the fa	all on 6/2/2023 and added			
	_	e fell after dinner but could not		On 7/25/23, the therapy manager	
		e time. Resident #94		completed education with the therapists	
	· •	ouldn't recall if the lights were		related to ensuring resident pain concer	
		Resident #94 reported she		are immediately reported to the therapy	
		s on her feet, and she fell		manager and the Director of Nursing.	
		osite to the bathroom door		Therapy staff to include occupational	
		Resident #94 recounted that screamed" (for help) and "2		therapist, physical therapist, speech	
		and got me into bed, I		therapist, new hires, weekend staff and prn staff will not be allowed to work until	
	, ,	e entire time." Resident #94		they receive this education.	'
		d every time I was touched or		On 7/21/23, the Unit Managers and	
		I never got pain medication."		Weekend supervisor were educated by	
		ed she had called her family		the Director of Nursing that they are	
		3 to report the fall. Resident		responsible to complete daily audits to	
		as "10 out of 10 all the time,		ensure that resident progress notes,	
	they did not do anyt	hing for it." Resident #94		physician orders, therapy notes and	
	explained she had a	nn x-ray that showed her right		medication records are being reviewed	to
		nd she was sent to the		ensure resident pain concerns have bee	en
		94 reported she cried about		addressed and intervention for	
		ery time someone came into		management and prevention of pain are	;
	her room and that it	was "horrible pain."		in place.	
	The family member	of Resident #94 was		The Director of Nursing will complete	
	interviewed by phon	e on 7/20/2023 at 4:19 PM.		audits on at least 10 current residents	
	The family member	reported that Resident #94		weekly for 4 weeks and monthly for 2	
	called him at 7:10 P	M on 6/2/2023 to tell him that		months to ensure that residents continu	
		she was having pain in her		to be assessed for signs and symptoms	
		nber explained that Resident		pain, resident pain concern continues to	
		members had picked her up		be addressed, pain care plans develope	ed,
		didn't think he needed to call		and pain documentation is completed.	
		the fall. The family member			
	1	visit Resident #94 on		The Director of Nursing will submit the	
		to Nurse #1 and reported		findings to the Quality Assurance	
	I .	ad fallen and was having pain.		Performance Improvement (QAPI)	
		reported that the nurse got		committee monthly meeting for 3 month	S
		over-the-counter pain stered the medication to		for review and follow up with recommendations to ensure the facility.]e
	i ronovor <i>j</i> ariu aurillili	Stored the inedication to	1	1000111110110ations to chould the lability	J

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCOR	345130 RD		STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 697	he visited again on Sithe nurse on duty above walker, and he also many many many many many many many many	mily member explained that unday, 6/4/2023 and asked out getting Resident #94 a mentioned the fall and pain to ed about the nurse's member said the nurse did ut the reported fall. The ed he had called the mber and left her a voice on Monday, 6/5/2023. The ned that an x-ray wasn't 6/5/2023 after NP #2 94. as ordered on 6/2/2023 to a per day. Pation orders for Resident eduled or as needed pain escribed for her 6/2/2023, or 6/5/2023. Standing orders included acetaminophen, to Resident #94's medical enistration record for June No administration of documented for Resident for 6/5/2023. Pation or 7/21/2023 at 4:49 PM. Pation of 7/21/2023 at 4:49 PM. Pation of 7/21/2023 when Resident the facility, and she had atthroom. NA #3 indicated	F 69	continued compliance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.
F 697	pivoting to sit and the the transfers or any e 6/2/2023. An interview was con 12:04 PM with NA #7 provided care to Res afternoon shift. NA # experienced urinary i report pain and she coshift. The pain assessment 6/2/2023, 6/3/2022, 6/3/2022, 6/3/2022, 6/3/2022, 6/	e toilet by standing and e resident had no issues with episodes of incontinence on aducted on 7/21/2023 at and she reported she ident #94 on 6/2/2023 for the error to the error and the error and the error and the error and the error at fall during her and she documented a to with 10 being the most ewed on 7/19/2023 at 4:05 that she was assigned to the efternoon shift on the efternoon shift on the error and the error at 10 with 10 being the most expected and the error and th	F 697		
	not expressed she will Nurse #2 conducted those dates. A follow up interview at 1:44 PM revealed #94 was experiencing or 6/5/2023 during he reported that no one fall or was experienci indicated that when sassessment for Resid 6/3/2023, 6/4/2023, a denied pain. Nurse # notice swelling or brut	s/4/2023, and 6/5/2023 had as in pain at all to her when the pain assessments on with Nurse #2 on 7/25/2023 no one reported Resident g pain on 6/3/2023, 6/4/2023, er afternoon shift. Nurse #2 reported Resident #94 had a ng hip pain. Nurse #2 she performed the pain dent #94 on 6/2/2023, and 6/5/2023, the resident #2 reported she did not lising of Resident #94's right shifts. Nurse #2 reported			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.75
F 697	work on 6/5/2023 for #2 reported she waite to the physician but we sent until after the endenied conducting ar #94, except for the dawn was recompliant of the fall and subsequent passessment." There was no evident any nurse notified the fall and subsequent passessment of Resid ordered on 6/2/2023. Day shift (7:00 AM to assessment recorded pain level of "0'. Nurse #1, an agency Resident #94 on 6/3/2 AM to 3:00 PM). Multi Nurse #1 for an interview.	fall when she arrived for the afternoon shift. Nurse ad for the x-ray results to call was told the results were not do fher shift. Nurse #2 by assessments on Resident aily shift pain assessment. to 7:00 AM) 6/2/2023 pain orded as "0" by Nurse #9. ducted with Nurse #9 by at 11:33 AM. Nurse #9 do not frequently work ay (C), but she was assigned //2023. esident #94 did not report med the pain assessment or ng the shift, and Nurse #9 ent reported pain, I would reddressed it in the pain completed an ent #94 or that an x-ray was	F 69		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING	_FINI/	C 07/28/202<u>3</u>
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		51	REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE DNCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 697	Continued From pa	ge 53	F 697		
	NA #1 reported she #94 on 6/3/2023 an NA #1 reported Res weekend when they reported she had re on 6/3/2023. NA #1 get out of bed on da 6/4/2023 and she re bed because of the NA #6 was interview and he reported he on 6/2/2023, 6/3/20 Resident #94 had reported the pain. The weekend superinterviewed by phon Nurse #3 reported \$6/4/2023 from 7:00	wed on 7/20/2023 at 11:57 AM. was assigned to Resident d 6/4/2023 for the day shift. sident #94 had pain during the moved her in bed. NA #1 reported the pain to Nurse #1 reported Resident #94 did not ay shift for 6/3/2023 or required incontinence care in right hip pain. wed on 7/20/2023 at 12:01 PM worked day and evening shift 23 and 6/4/2023 and if reported pain, he would have rvisor Nurse #3 was ne on 7/20/2023 at 1:39 PM. she worked 6/3/2023 and AM until 11:00 PM and no resident #94 was experiencing			
	pain. A physical therapy and dated 6/3/2023 #94 reported right having pain in her reported right having pain in her reported reported in the reported reported in the reported reporte	evaluation performed by PT #1 documented that Resident iip pain from a fall 6/2/2023. ed the physical therapist unnamed) Resident #94 was			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.475
F 697	touch. Resident #94 the evaluation without was leaning to the rigwent to the nursing sand reported the fall #94 was experiencing unknown nurse and to order for an x-ray for certain the time of date #94. PT #1 was unable the nurse or the time. The Director of Rehaman 7/25/2023 at 8:59 AM Rehabilitation reported work on 6/3/2023 at 3:4 An occupational ther 6/3/2023 was review documented that Resinterfered or limited for location) and that nurman agement. The note that the sident #94 reported and she had pain in 18 The Occupational The interviewed on 7/25/207 #1 reported she as on 6/3/2023 and Resident #94 reported she as on 6/3/2023 and Resident #94 reported she as on 6/3/2023 and Resident #94 reported she as on 6/3/2023 and Resident was the floor. OT #1 in did not have pain during the floor. OT #1 in did not have pain during had not gotten Resident.	ed right hip pain to her with was unable to stand during at moderate assistance and ght. PT #1 indicated she station and looked for a nurse and the pain that Resident g. PT #1 reported an told her she would get an Resident #94. PT#1 was not all she evaluated Resident ple to provide the name of a she reported to the nurse. Abilitation was interviewed on the provide the nurse of the provide the nurse. Abilitation was interviewed on the provide the nurse of the provide the nurse. Abilitation was interviewed on the provide that PT #1 clocked in to 3:46 PM. Approvaluation dated ed. The evaluation note sident #94 had pain that functional activity (no rating would address pain one documented that ed she had a fall on 6/2/2023 the right leg. All provided the provided she had a fall on 6/2/2023 the provided she had a fall on 6/2/2024 the	F 697		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCO	345130 RD	J 5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 697	assigned to Resident afternoon shift. The I #94 complained of preport to any nurse b PT #1 reporting the prepart explained she did not received the report for the two of them talking to get out of bed duriful 6/3/2023 because of with moving. NA #2 rebruising on Resident There was no evider any nurse notified the fall and subsequent passessment of Resident assessment of Resident assessment of Resident #3 was interviat 1:53 PM and she in Resident #94 during reported Resident #94 was in pain at all to be the pain assessment reported she remember requesting a on 6/4/2023. Nurse #8 Resident #94 was very pain. Nurse #8 reportall to her.	M. NA #2 reported she was at #94 on 6/3/2023 for the NA explained that Resident ain in her hip, but she did not ecause she had observed to be ain a nurse. NA #2 at remember the nurse that som PT #1, but she had seen and. Resident #94 was unable and the afternoon shift on the pain she experienced reported she did not notice #94's right hip. Acce in the medical record that the physician of Resident #94's pain, completed an alent #94, or that an x-ray was are the for day shift on 6/4/2023 reported she was assigned to the day shift on 6/4/2023 and the had not expressed she are when Nurse #8 conducted on 6/4/2023. Nurse #8 reported she recalled that ary pleasant and not in any ted that no staff reported a	F 697		
	and 6/4/2023 were re	t for night shift on 6/3/2023 ecorded by Nurse #7 as "0". ewed by phone on 7/21/2023			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WINGSTF	REET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDI	US HEALTH AT CONC	ORD		LAKE CONCORD ROAD NE NCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 697	had not complained conducted the pain or 6/4/2023 on the rexplained that Residual administer acetamin she did administer the treported the resipain, and she had reacetaminophen at 60 NA #5 was interview NA #5 reported she #94 on 6/4/2023 for unable to recall if Resident #94 during the night shift There was no evide any staff notified the fall and subsequent	#7 reported that Resident #94 of pain when Nurse #7 assessment during 6/3/2023 hight shifts. Nurse #7 dent #94 had an order to hophen at 6:00 AM daily and he medication to her. Nurse dent had not complained of eceived scheduled :00 AM on 6/3 and 6/4/2023. Wed on 7/21/2023 at 11:33 AM. was assigned to Resident the night shift. NA #5 was esident #94 required uring her shift and reported id not complain of pain to her t. nce in the medical record that e physician of Resident #94's	F 697		
	-	nt day shift on 6/5/2023 #6 documented a pain level of			
	PM. Nurse #6 repo admitted Resident # also assigned to he reported Resident # when Nurse #6 con and if she had repo standing orders she administering aceta Nurse #6 explained	riewed on 7/21/2023 at 12:10 rted she was the nurse who 494 on 6/2/2023 and she was r on 6/5/2023. Nurse #6 94 did not report pain to her ducted the pain assessment., rted pain, there were facility could have activated for minophen to Resident #94 to her, she did not activate the			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCOL	345130 RD	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.75
F 697	4:49 PM, NA #3 repo 6/5/2023 and was as: the day shift, and who care, Resident #94 yo leg!" NA #3 reported day shift Resident #9 incontinence brief on care. NA #3 explained and when they return NP #2 was at the bed Resident #94 was un yelling out in pain. NA #94 experienced pair had to get another NA incontinence care for her pain level. NA #3 her pain was in her right and severe with any leturning for incontinence painful. NA #3 report #94 was able to get us stayed in bed all day incontinence care in the A progress note writted documented Resident 6/2/2023 she attempt and had a fall with pafall). The NP docume increased pain/discor was noted, and the home the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that and described as "ac Resident #94 had "asserted the right hip/thigh that hip the right hip/thigh that and the right hip/	onducted on 7/21/2023 at red she returned to work on signed to Resident #94 on en she attempted to provide elled in pain "my leg, my on Monday 6/5/2023 for the 4 was in bed with an and required incontinence d she went to get Nurse #6, ed to Resident #94's room, lside. NA #3 described that able to move in bed without A #3 explained that Resident all day on 6/5/2023 and she A to assist her with Resident #94 because of a reported Resident #94 said ght hip and it was very sharp kind of movement and ce care was unbearably ed on 6/2/2023 Resident pt to the bathroom, but she 6/5/2023 and received	F 69	7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING	TIVI /	C 07/28/202<u>3</u>	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			515 L	ET ADDRESS, CITY, STATE, ZIP CODE AKE CONCORD ROAD NE CORD, NC 28025	AL.	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
F 697	NP #2 was intervied NP #2 reported she admission assessr 6/5/2023 when Repain and fall. NP # x-ray of Resident # was read and it was had a fracture, she evaluation. An interview was confirmed to a fracture of the reported she to was in pain. A hip x-ray dated 6	an x-ray result were received. wed on 7/21/2023 at 2:45 PM. was performing the nent on Resident #94 on sident #94 reported the hip 2 explained she ordered an 294's hip and when the x-ray 3 determined Resident #94 was sent to the hospital for onducted with NA #4 on AM. NA #4 reported she neontinence care on 6/5/2023 on shift and Resident #94 was shift. NA #4 reported she de incontinence care by sused Resident #94 to "scream on. NA #4 explained that she NA to assist her with care. NA dd Nurse #2 that Resident #94	F 697			
	A nursing note date documented the received by the factor the on-call NP was received an order thospital for evaluating the note document facility by ambulan There was no evident.	oital fracture with moderate the right hip fracture). and 6/6/2023 at 12:31 AM asults of the hip x-ray were stility at 11:45 PM on 6/5/2023. It is paged, and the nurse to send Resident #94 to the stion for the right hip fracture. It is that Resident #94 left the ce at 12:30 AM. The results of the medical record that the service of the right hip fracture.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER US HEALTH AT CONCOL	345130 RD	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 697	dated 6/6/2023 at 1:2 #94 presented with right to be fractured on an earlier that day. Resist three days ago and his since. The note docurby the facility showed exam the ED physicial right hip without defor obtained confirmed a femoral neck fracture or documentation of right. Orthopedic surg 3:05 AM recommend admitted and make his status. It was unknown pain medication during for evaluation on 6/6/ An orthopedic trauma 6/6/2023 at 10:40 AM (Resident #94) report was attempting to get landing on her right hip ain in the right hip a after the fall. The hist "Right lower extremity (redness). Leg length contralateral leg (left rotation (leg was rota (agreed) hip pain with to the floor during moassessment and planneck fracture was dis and the recommendathip hemiarthroplasty,	rtment (ED) provider note 8 AM documented Resident ght hip pain that was found x-ray obtained outpatient dent #94 reported she fell as had right hip pain ever mented the x-ray obtained a right hip fracture. On an noted tenderness to the mity. Repeat x-rays closed subcapital right . There was no pain rating, medications administered for yery was consulted and at ed for Resident #94 to be er NPO (nothing by mouth) wn if Resident #94 received gg transport to the hospital 2023. It consult note dated I documented: Patient led on Friday 6/2/2023 she is up to the bathroom and fell, ip. She reported immediate and being unable to get up ory and physical noted: y: skin intact without short in comparison to leg) and hip held in external ted to the right). Endorses in heel strike (touching heel	F 69		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD				LAKE CONCORD ROAD NE NCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 697	An interview was co 7/21/2023 at 11:54 medical group has a NP is available 24 h questions and provi that the facility had triage for anything r /2/2023, 6/3/2023, 6 MD reported that de fractured large bone painful for Resident she did not have an The Director of Nurson 7/21/2023 at 3:2 that she had though reported the fall to a NP #2 assessed he not aware of the phyconducted on 6/3/20 to an unknown nurs and was experienci interviewed Residen NP evaluation and I had fallen and gotted did not report the fa staff should have im on-call NP and reports assessed Resident was not certain why 6/3/2023.	ted Resident #94 was er own consents. Inducted with the MD on AM. The MD reported that his an on-call triage line where a cours a day to answer medical de orders. The MD reported not contacted the on-call elated to Resident #94 6 6/4/2023, or 6/5/2023. The elaying treatment for a e would have been very #94, and he was not aware order for pain medication. Sing (DON) was interviewed 1 PM. The DON explained at Resident #94 had not anyone until 6/5/2023 when are. The DON reported she was yeical therapy assessment D23 and that PT #1 reported e that Resident #94 had a falling pain. The DON stated she are that Resident #94 reported she and herself up off the floor and all to staff. The DON explained amediately contacted the arted the fall and pain and #94. The DON reported she this had not happened on are notified of Immediate	F 697		
	o Identify those reci	pients who have suffered, or			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		518	REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE DNCORD, NC 28025	C 07/28/202<u>3</u>	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 697	a result of the nonco. The facility failed to resident representation reported to the Physical she had fallen in her. On 6/3/23, the physical revealed that Reside physical therapist that her room and had not facility staff. The physical the resident compared that she woorder for an x-ray. On 7/21/23, the Direct Nurse #1, and she does not reported that she woorder for an x-ray. On 7/21/23, the Direct Nurse #1, and she does not reporting to her that addition, Nurse #1 work requested pain medical symptoms of pain and the physical therapist that she reported that Reher that she had falled to go to the bathroom reported that the room resident had fallen on On 6/5/23, after the light that Resident #94 red Director of Nursing of the physical of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that Resident #94 red Director of Nursing of the physical therapist that the physical therapist t	serious adverse outcome as mpliance notify the physician and/or the ve after Resident #94 ical Therapist on 6/3/23 that	F 697		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		1 5	STREET ADDRESS, CITY, STATE, ZIP CODE 115 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / 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 APPROPRIA DEFICIENCY)	DATE
find the control of t	and gotten herself up eported this to the state of the st	g to go to the bathroom and off the floor and had not aff. ger #1 and the Admissions ident #94's family member 6/2/23, Resident #94 had he had fallen on the way to the she was having a lot of ber reported that he the the the the the the the the the	F 697		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP		
	ROVIDER OR SUPPLIER US HEALTH AT CONCOR	345130 RD	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 115 LAKE CONCORD ROAD NE CONCORD, NC 28025	07/2	28/202 <u>3</u>
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	did not report the fall nurse, certified nursin medication aide. On 7/17/23, Nurse #3 interview with the Dire that Resident #94 did and she did not observex cruciating pain on 6 also reported that Resident report that Resident Resident report that Resident Resident report that Resident Resident report that Resident	4/23 per the nursing vealed that Resident #94 to the assigned licensed g assistant or certified (Weekend Supervisor) ector of Nursing revealed not express pain concerns eve signs or symptoms of 3/3/23 and 6/4/23. Nurse # 3 sident #94 as well as the include the physical on 6/3/23 and 6/4/23, did ent #94 has fallen on 6/2/23. At Resident #94's family to her that the resident that the resident that the resident had fallen are also at risk as a result of Director of Nursing/the Unit the ewill complete an audit of poinclude review of progress er notes, incident reports, ation records, physician hift reports of all the current 60 days to ensure the extenders and resident been notified of any resident and identified address by 7/25/23. Director of Nursing / e interviews of the alert insure resident concerns to	F 697			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER US HEALTH AT CONCOR	345130 RD	5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D 4.T.E.
F 697	resident care concern reported to the physic the last 60 days by 7/2 Starting 7/21/23, the Idesignee will complet staff to include license assistants, certified minousekeeping/laundry staff to ensure all residence reported concernse been reported to the Identity the Nursing supervisor of Specify the action the Process or system fail adverse outcome from when the action will be Starting 7/21/23, the Starting 7/21/23, the Starting 7/21/23 of the facility nurses, certified nursimedication aides, died housekeeping/laundry staff related to ensuring concern, resident care	tion/ treatments and other is have been identified and ian/ physician extenders in 25/23. Director of Nursing/ ie interviews of the facility ied nurses, certified nursing edication aides, dietary, if agency, new hire and product changes in condition or is in the last 60 days have DON, Unit Manager and/or is by 7/25/23. The entity will take to alter the lure to prevent a serious in occurring or recurring, and ie complete Staff Development is will complete education by its staff to include licensed in gassistants, certified itary, therapy department, if agency, new hire and printing resident changes in cident and accidents, pain is, medication/treatment is concerns and any inted concerns have been ied nurse and to the	F 697		
	_	e will complete education es to include agency, new			

NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (CACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (CACH DEFICIENCY) F 697 Continued From page 65 (Immediate notification and documentation of resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident framilies reported concerns to the physician/ physician extenders and resident representatives and document in the medical record by 7/25/23. After hours the licensed nurse will notify the on-call provider and document in the medical record by 7/25/23. After hours the licensed nurse will be responsible for verifying that the education has been completed by the required staff members by using the facility personal roster and the nursing, dietary, therapy and housekeeping/laundry staffing schedules to include new hires, agency and pri staff and ongoing education by 7/25/23. After Solvand and the decident on by 7/25/23. After solvand and the education by 7/25/23. After solvand and the decident on by 7/25/23. After solvand and the education of the representation of the providing all of the education. On 7/25/23, The Director of Nursing educated the therapy manager to ensure that all therapists to	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
FREEIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 697 Continued From page 65 immediate notification and documentation of resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident/ families reported concerns to the physician/ physician extenders and resident representatives and document in the medical record by 7/25/23. After hours the licensed nurse will notify the on-call provider and document in the medical record. Starting 7/21/23, the Staff Development Coordinator was made aware by the Director of Nursing that she will be responsible for verifying that the education has been completed by the required staff members by using the facility personal roster and the nursing, dietary, therapy and housekeeping/laundry staffing schedules to include new hires, agency and prn staff and ongoing education by 7/25/23. No staff will be allowed to work until they have received this education. The SDC/ designee which includes the DON, Unit Managers, and Nursing supervisors will be responsible for providing all of the education. On 7/25/23, The Director of Nursing educated the therapy manager to ensure that all therapists to				B. WING	515 LAKE CONCORD ROAD NE	
immediate notification and documentation of resident changes in condition to include incident and accidents, pain management changes, medication/treatment concern, resident care concerns and any resident/ families reported concerns to the physician/ physician extenders and resident representatives and document in the medical record by 7/25/23. After hours the licensed nurse will notify the on-call provider and document in the medical record. Starting 7/21/23, the Staff Development Coordinator was made aware by the Director of Nursing that she will be responsible for verifying that the education has been completed by the required staff members by using the facility personal roster and the nursing, dietary, therapy and housekeeping/laundry staffing schedules to include new hires, agency and prn staff and ongoing education by 7/25/23. No staff will be allowed to work until they have received this education. The SDC/ designee which includes the DON, Unit Managers, and Nursing supervisors will be responsible for providing all of the education. On 7/25/23, The Director of Nursing educated the therapy manager to ensure that all therapists to	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION
include occupational therapist, physical therapist, speech therapist, weekend therapist, new hire, and prn therapist report resident observed and reported falls to the therapy manager and the Director of Nursing immediately. Starting 7/25/23, the therapy manager will educate the therapists to include occupational therapist, physical therapist, speech therapist, weekend therapist, new hire, and prn therapist	F 697	immediate notification resident changes in cand accidents, pain in medication/treatment concerns and any resconcerns to the physiand resident represent medical record by 7/2 licensed nurse will not document in the med. Starting 7/21/23, the Coordinator was mad Nursing that she will be that the education has required staff member personal roster and than thousekeeping/lainclude new hires, agongoing education by allowed to work until education. The SDC/DON, Unit Managers will be responsible for education. On 7/25/23, The Direct therapy manager to expect therapist, we and printherapist reported falls to the the Director of Nursing in Starting 7/25/23, the educate the therapist therapist, physical the	and documentation of condition to include incident condition to include incident canagement changes, concern, resident care sident/ families reported ician/ physician extenders contained and document in the extreme contained and document in the extreme contained and document in the extreme contained and conta	F 69	97	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	345130	B. WINGST	REET ADDRESS, CITY, STATE, ZIP CODE	C 07/28/202<u>3</u>	
ACCORDIUS HEALTH AT CONCORD		51	5 LAKE CONCORD ROAD NE ONCORD, NC 28025	` _		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		٧
F 697	therapy manager and Therapy staff to inclu not be allowed to unt Effective 7/21/2023 the responsible for ensuring immediate jeopardy mon-compliance. Alleged Date of IJ Responsible for ensuring immediate jeopardy mon-compliance. Alleged Date of IJ Responsible for ensuring immediate jeopardy mon-compliance. The facility provided the Credible Allegation Nurse Practitioner as and sent her to the heright subcapital fracture provided documentate all residents in the facility. An in-service with the nursing and resident pain identification management of pain of pain, and update of further provided the eprovided to all new here garding pain managed to work in the facility. Interviewed regarding education provided. In amed resident and a service of the	nediately reported to the I the Director of Nursing. de prn and new hire staff will ill they receive this education. The Administrator will be ing implementation of this emoval for this alleged The moval: 7/26/2023 The facility's credible allegation for emoval was validated by the documentation to support on for F697. The facility's sessed the named resident ospital for evaluation of a re. The facility further ion of pain assessment for cility. The facility further oain assessments, pain medication management, odates for all residents in the education was completed therapy staff regarding fation, signs of pain, medication, documentation of the care plan. The facility education that will be	F 697			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	C 07/28/202<u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.
F 697	and the education of s 7/25/2023. The facility's date of the removal plan of 7/26/2	e 67 ent, and care plan update; staff were completed by ne immediate jeopardy 2023 was validated on	F 697		
F 812 SS=E			F 812		8/26/23
	state or local authoriti (i) This may include for from local producers, and local laws or regulii) This provision doe facilities from using progardens, subject to consafe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accordant standards for food set This REQUIREMENT by: Based on observation record review, the faction one freezer free of action pooled water on the knoccurred for approximation.	ed satisfactory by federal, es. pod items obtained directly subject to applicable State alations. Is not prohibit or prevent roduce grown in facility compliance with applicable d-handling practices. Is not preclude residents Is not procured by the facility. In prepare, distribute and Ince with professional		The Maintenance Director removed the accumulated ice from the freezer on 7/18/23. The Freezer compressor was repaired an outside contractor on 7/25/23. The current residents have the potentia be affected. The Maintenance department	by I to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 07/28/2023
NAME OF P	ROVIDER OR SUPPLIER		/	STREET ADDRESS, CITY, STATE, ZIP CODE	
			515 LAKE CONCORD ROAD NE		
ACCORDIUS HEALTH AT CONCORD		CORD		CONCORD, NC 28025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 812	Continued From pa	age 68	F 812	2	
	The findings includ	led:		and/or the dietary staff will check on th	е
	-			freezer ice accumulation daily and ens	ure
	1. An observation	of the walk-in freezer occurred		that the ice accumulation is removed u	ntil
		5 AM. A metal storage rack		the new freezer compressor can be	
	''	nches in height was observed		installed.	
		ored on top. The milk crates		The Maintenance Department staff and	i
		y 11 inches in height. Multiple		the dietary staff will be educated by	
		ns, crinkle cut French fries and stored on top of the milk crates.		8/25/23 by the Administrator related to	ia
	•	on top of these cases of food		ensuring that freezer ice accumulation checked daily, and ice accumulation is	I
		extended to the floor,		removed until the new freezer compres	I
		nches and pooled on the floor		can be installed.	3301
		f the metal storage rack. The		The maintenance department staff and	
		ved inside the cases of food		the dietary staff, to include agency diet	
	items and on the fo	ood. The freezer compressor		staff, will not be allowed to work until the	
	was observed with	ice accumulation and water		education is completed. New hires also)
	dripping.			will be required to complete the educat	ion.
		ger (DM) stated in an interview		The Administrator/ Dietary Manager wi	
		5 AM that compressor had		check the ice accumulation daily until t	
		e past two weeks, the		new freezer compressor is installed an	
		ctor was aware and ordered a		then monthly for 2 months to ensure th	at
		that the part had not arrived		ice is not accumulating in the freezer.	
		d that she and the Maintenance g to remove the ice buildup in		The Administrator/ Dietary Manager wi	ıı İ
	l	it due to amount of water		submit the findings to the Quality	"
	leaking from the co			Assurance Performance Improvement	
		hard to keep removed.		(QAPI) committee monthly meeting for	3
				months for review and follow up with	
	An interview with the	he Maintenance Director		recommendations to ensure the facility	's
	occurred on 7/17/2	23 at 12:12 PM. He stated that		continued compliance.	
		ne called for a repair service to			
		pecause the compressor was			
		part of the repairs were			
		t a part that was needed to			
		rs had been ordered, but had			
		ted the repair service came to			
		eeks ago to complete the			
	⊢repairs, and identif	fied a part that was needed and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130 NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025		C 07/28/202<u>3</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 812	ordered the part. stated that the collection he tried to remove as possible. He say on Friday, 7/14/23 coming up with a but that he had not yet. He stated that ice accumulation plan for removing part came in for return of the invoice from the residence invoice from the residence as a during the repair. The lock to the collection was recorded as a during the repair. The Administrator 3:10 PM and state was waiting on a the freezer. He state removed in the interest that in the part for repair. 2. An observation 11:28 AM reveale water pooled on the was incompleted.	The Maintenance Director impressor was leaking and that a the ice accumulation as often aid he saw the ice accumulation and spoke to the DM about plan to remove the ice build-up, at had a chance to address it at he would start checking for more frequently and develop a the ice accumulation until the epair. Director provided a copy of the epair service provider. The date 2/5/23 and recorded the was to repair the walk-in efrigerant to the walk-in freezer susted and leaking and broke off at was replaced. The drain line pressor was also in need of a drain to freeze up. This repair the. was interviewed on 7/20/23 at the drain to freeze up. This repair the compressor in ated that the ice should be derim while the facility waited on of the kitchen on 7/17/23 at a drain to freeze up. This repair the drain the facility waited on the floor in the dish pit area obten floor tiles were observed.	F 812		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER ACCORDIUS HEA		345130 RD	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202<u>3</u>
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
Review and 6/ recommin the clean// During Dietar dish p since The Dietar dish p since The Bie dietar dish p since The Ar 7/20/2 kitchel and as He stakept c QAPI/ SS=E CFR(s §483.7 monitor A facil policie collect advers process following system from direside	dish pit area, and dry. g an interview of y Manager (DM) it area had bee piping was replayed that a correct where the tile hopped this area dministrator stated that a correct where the tile hopped this area dministrator stated that he explean and the floo QAA Improvem (a): 483.75(c)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)	vice reports dated 3/27/23 I kitchen sanitation remove excess water noted and to keep the area In 7/19/23 at 1:10 PM the I) stated the floor tiles in the aced in the kitchen last year. Is a result, water pooled on les were broken/missing and a daily, but water still pooled Ited in an interview on leat the piping underneath the laired in the summer of 2022 floor tiles still needed repair. In elected the dish pit area to be altered to the summer of the summer	F 812		8/26/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			, ,	STREET ADDRESS, CITY, STATE, ZIP CODE S15 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 867	opportunities for imp §483.75(c)(2) Facility systems to identify, of information from all of not limited to the facility systems to identify, of information from all of not limited to the facility and limited to the facility and evaluation of per including the method development, monitor §483.75(c)(4) Facility including the method systematically identify analyze and use data adverse events in the facility will use the da prevent adverse eve §483.75(d) Program systemic action. §483.75(d)(1) The fa aimed at performance implementing those a and track performance improvements are re §483.75(d)(2) The fa implement policies a	dume, or problem-prone, and rovement. If maintenance of effective collect, and use data and departments, including but lity assessment required at ding how such information op and monitor performance If development, monitoring, formance indicators, cology and frequency for such oring, and evaluation. If adverse event monitoring, as by which the facility will by, report, track, investigate, a and information relating to be facility, including how the lata to develop activities to ents. If a systematic analysis and If a cility must take actions to entire improvement and, after actions, measure its success, be to ensure that alized and sustained. If a cility will develop and didressing: a systematic approach to greater the college of problems	F 867		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			51	REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE DNCORD, NC 28025	07/2	28/202 <u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	will be designed to a level to prevent qual safety problems; and (iii) How the facility of its performance in ensure that improve §483.75(e) Program §483.75(e)(1) The fiperformance improved high-risk, high-volund consider the incider of problems in those outcomes, resident resident choice, and §483.75(e)(2) Performance improved activities must track resident events, and implement prevention that include feedback facility. §483.75(e)(3) As particularly a project the available resources assessment required annually a project the problem-prone area.	velop corrective actions that effect change at the systems lity of care, quality of life, or d will monitor the effectiveness mprovement activities to ements are sustained. activities. activities. activities that focus on me, or problem-prone areas; noe, prevalence, and severity e areas; and affect health safety, resident autonomy, d quality of care. Trance improvement medical errors and adverse alyze their causes, and ve actions and mechanisms ock and learning throughout the ency of improvement projects. The noty of improvement projects cility must reflect the scope ne facility's services and, as reflected in the facility d at §483.70(e). The noty of improvement projects in the facility dat §483.70(e). The noty of improvement projects is identified through the data was identified through the data was identified through the data was identified in paragraphs	F 867			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD ROAD NE CONCORD, NC 28025	C 07/28/202 <u>3</u>
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5475
F 867	§483.75(g)(2) The quassurance committee governing body, or defunctioning as a gove activities, including improgram required under the governing body, or defunctioning as a gove activities, including improgram required under the government of the	ality assessment and 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 diffied quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on	F 867	Quality Assessment and Assurance (QAA) Committee will be held on 8/24/3 by the Administrator related to ensuring the facility has effective systems to obtainformation and/or feedback from facility staff, residents and residents representatives to identify problems an opportunities for improvement. The identified tags will be reviewed to include the repeat tags. The current residents are at risk related this deficient practice. The Administrator was educated on 8/23/23 by the Director of Operations related to ensuring the QAA Committe maintain and implement processes to obtain information and/or feedback from	e e
		iring a recertification and in and in and on 7/29/2022 during a		facility staff, residents and residents	n

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 07/28/2023
NAME OF P	ROVIDER OR SUPPLIER		<i>J</i> :	STREET ADDRESS, CITY, STATE, ZIP CODE	~ -
				515 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CON	CORD		CONCORD, NC 28025	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 867	Continued From p	page 74	F 867	,	
	complaint investig	ation. These deficiencies were		representatives to identify problems ar	nd
	cited again during	the facility's current		opportunities for improvement.	
		complaint investigation survey			
		e continued failure of the facility		The interdisciplinary team to include the	
		l surveys of record shows a		Director of Nursing, Administrator, Soc	
	·	lity's inability to sustain an		Services, Dietary Manager, Housekee	
	effective QAA Pro	gram.		Manager, Maintenance Director, Busin	
	Ti f:i: ii	al - al.		Office Manager, Therapy Manager, St.	атт
	The findings inclu	aea:		Development Coordinator, Medical	and
	This tag is cross r	oforonced to:		Records, Admission, Activity Director, Medical Director will be educated on	anu
	Tills tag is closs i	eleleliced to.		8/24/23 by the Administrator related to	
	F580-Based on re	ecord reviews, resident, family,		ensuring the QAA Committee maintain	
		(NP), physician (MD), and staff		and implement processes to obtain	
		cility failed to notify the MD of a		information and/or feedback from facili	ty
		erienced pain following a fall for		staff, residents and residents	
		vestigated for notification of		representatives to identify problems ar	nd
	changes. The res	sident sustained a fall on		opportunities for improvement.	
	6/2/2023 and repo	orted the fall and right hip pain to			
		t (PT) #1 on 6/3/2023. PT #1		The Administrator will be responsible for	or
		nd the hip pain to a nurse. The		monitoring the Quality Assurance	
		the fall and right hip pain when		Performance Improvement Plan proce	
		d by NP#2 on 6/5/2023. NP#2		monthly for 3 months to ensure that the	
	_	of the right hip, which revealed a		facility remains in compliance for ident	itied
		he long bone in the leg). She ospital on 6/6/2023 at 12:30 AM		deficiencies.	
		hip replacement surgery on		The Administrator will report the finding	ne -
	6/7/2023.	nip replacement surgery on		of the audits in the monthly Quality	J S
	0/1/2020.			Assurance Performance Improvement	
	During the focuse	d infection control and		(QAPI) meeting for at least 3 months for	
	_	ation survey conducted on		review to ensure compliance.	
		was cited for failing to notify a		,	
		ian when two doses of an			
		nti-seizure) medication were not			
	available to admir	nister on 03/18/22. The resident			
		of seizure activity and required			
		ns to control the seizure activity			
		1/22 and 03/24/22-03/28/22 for			
	1 of 3 residents re	eviewed for medication			

Facility ID: 953050

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			REET ADDRESS, CITY, STATE, ZIP CODE S LAKE CONCORD ROAD NE DNCORD, NC 28025	C 07/28/202 <u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 867	investigation survers facility was cited for Physician when two medications were on 07/21/21 and 0 pressure reading was residents review management. During the focused complaint investiga 8/31/22 the facility the provider of skin 3 residents review F655- Based on resinterviews, the factorial care plan within 48 addressed the need of frequent falls for baseline care plan. During the recertification survers facility was cited for care plan within 48 the immediate need feedings or identify 1 of 2 residents resid	cation and complaint by conducted on 2/14/22 the or failing to notify a Resident's or different blood pressure not available for administration or 7/22/21; and when the blood was out of normal range for 1 of ed for medication d infection control and ation survey conducted on was cited for failing to notify a assessment changes for 1 of ed for pressure ulcers. coord reviews and staff lity failed to develop a baseline or hours of admission that eds of a resident with a history or 1 of 29 residents reviewed for	F 867		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING	TINI/	C 07/28/202<u>3</u>	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			515 L	ET ADDRESS, CITY, STATE, ZIP CODE AKE CONCORD ROAD NE CORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 867	investigation surver facility was cited for hazardous food with system, and 2) sto and with a label ar thawed frozen dices submerged, under temperature of 93. facility stored hot of French fries, pancichicken tenders with opening and open of 3 cold storage utaffect food served. During the focused complaint investigation 7/29/22 the facility hand hygiene for 1 #1), monitor refrigereach-in refrigerate cold foods at least pimento cheese sa sandwich), and stopans) and a cutting	cation and complaint y conducted on 2/14/22 the r failing to 1) thaw a potentially th an effective food safety re cold/frozen foods sealed d date of opening. The facility d ham, that was not running water with a 4 degrees Fahrenheit (F). The logs, sliced ham, sliced turkey, lakes, sliced cheese and thout a label and date of to air. This failure occurred in 2 nits and had the potential to	F 867			
	During an interview 7/27/2023 at 1:43 Assurance Perform committee meets reduction and Pharm meeting every 3 meeting every 3 mestated the other meeting an interview of the stated stated the other meeting an interview of the stated sta	w with the Administrator on om he stated the Quality nance Improvement (QAPI) nonthly and the Medical nacist are present for the onths. The Administrator embers of the QAPI team are eting, which includes the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			l ⁵ ′	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE ONCORD, NC 28025	C 07/28/202<u>3</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D.T.	
F 925 SS=E	Therapy Manager, an Administrator stated the measures, grievances and trends for infection. The Administrator state the facility had repeat survey since he had july 12/1/2022. He stated to work on the issues survey and strive to in Maintains Effective Per CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain program so that the farodents. This REQUIREMENT by: Based on observation record review, the face effective pest control pobservations of current resident rooms, on two conference room. The insect light traps and in recommendations for reoccurring pest active. The findings included: 1 a. Observations of lithe following: On 7/17/23 at 12:33 flying around the covered.	Infection Preventionist, Indusekeeping Director, Indusekeeping Director, Indusekeeping Director, Industry Manager. The Industry Manager. I	F 925	On 8/8/23, the pest control service treated the C/D and the A/B units for flie to include rooms 116, 151, and 154. The conference room was treated for pests to include spiders on 8/8/3 by the pest control service. On 7/19/23, the Maintenance Director plugged the two wall mount insect light traps in the receptacle and notified the dietary manager. All current residents are at risk for this deficient practice. The Administrator followed up with Eco Lab on 8/8/23 to update the facility's current contract to include small flies peservices. Two Additional insect light traps were		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING _	E CONSTRUCTION (7	(X3) DATE SURVEY COMPLETED	
		345130	B. WING		C 07/28/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	\ -
			, 5	15 LAKE CONCORD ROAD NE	
ACCORDI	US HEALTH AT CONC	ORD	0	CONCORD, NC 28025	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E COMPLETION DATE
F 925	Continued From pa	age 78	F 925		
	- On 7/17/23 at 12:	55 PM, multiple small flying		scheduled to be added to the facility on	
	insects were obser	ved flying around the		8/18/23 by the Maintenance department.	
	nightstand in room	151 on the C/D unit.		Additional electrical receptacles will be	
	- On 7/17/23 at 12:	59 PM, flies were observed in		added to the kitchen by 8/25/23 to preve	nt
	room 154 on the Ca			unplugging of the current mounted wall	
		21 AM, multiple flies were /D unit flying around the open		receptacles.	
	food cart.			The Administrator by 8/25/23 will educate	e
	- On 7/19/23 at 11:	44 AM a spider was observed		the Maintenance Director and	
	_	or in the conference room.		Maintenance Staff related to ensuring the	at
		12:35 PM to 12:49 PM, flies		pest service recommendations are	
		the C/D unit around an open		implemented, follow up recommendation	ıs
	food cart.			completed, and insect light traps are	
				plugged into the receptacle.	
		1:10 PM, two wall mounted		The Administrator by 8/25/23 will educate	e
		ere observed unplugged in the		the Dietary Manager related to ensuring	_
		y Manager (DM) was		that insect light traps are plugged into the	е
		the observation and stated that difference that		receptacle. The Dietary Manager by 8/25/23 will	
		nd that she did not know what		educate the dietary staff related to	
		DM stated she had not noticed		ensuring that insect light traps are	
		traps were unplugged.		plugged into the receptacle.	
		anapa nara ampiaggaa.		The Administrator will complete audits	
	During an interview	v on 7/19/23 at 1:12 PM,		weekly for 4 weeks and monthly for 2	
		ted that she unplugged the		months to ensure that insect light traps	
	insect light trap in t	he cook's prep area to use the		are plugged in the receptacles and pest	
	electrical outlet and	d forgot to plug it back in.		service recommendations are being	
				addressed and the facility is following up	
		Director stated in an interview		on pest concerns. The Administrator will	I
		PM, that he noticed that the		submit the findings to the Quality	
		os in the kitchen were		Assurance Performance Improvement	
		t he was not sure who		committee meeting monthly for 3 months	5
		why. He stated they should be		for review to ensure the facilities	
	plugged in to deter	pest activity.		continued compliance.	
		of the kitchen on 7/17/23 at			
		puddles of brown colored			
		e floor in the dish pit area			
	where missing/brok	ken floor tiles were observed.			

PRINTED: 08/29/2023 FORM APPROVED OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD			1 5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	07/2	28/202 <u>3</u>
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F 925	7/19/23 at 1:10 PM. Pest control service re 6/19/23, both recomm water noted in the distarea clean/dry to reduce the common stated she was as reports and recommentate the floor tiles in the broken/missing for a water replaced in the kitcher stated that as a result where the tiles were be mopped this area dail there. 1 d. On 7/19/23 at 1:4 exterior facility ground items stored on the grather facility: Multiple boards of against the facility. "One broken show ground. "Four cement stain. "Five wooden palloground. "One black leather on the ground.	of the same occurred on eports dated 3/27/23 and ended to remove excess h pit area, and to keep the	F 925	DEFICIENCY)		
	ground. " Four particle boar footboards, broken, preshed.	rd headboards and ropped against the facility laying on the ground.				

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	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 5 LAKE CONCORD ROAD NE	07/2	28/202 <u>3</u>
ACCORDIUS HEALTH AT CONCORD			C	ONCORD, NC 28025		
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F 925	ground next to the "Three empty of ground." A pest control serv recommended the left outside, agains number of pests er An interview with the occurred on 7/19/2 Maintenance Direct November 2022, a months for the brolipicked up by the wistated that the cerroutside since the paccess a mobile kit summer of 2022. It black leather chair about a month ago broken items were ago. He stated that moving the broken was waiting on the emptied. He stated dumpsters were er but that he had beef or the waste remoon The Maintenance It these items were leaves his responsibilithe facility clean.	hairs, broken, stored on the open commercial dumpster. cardboard boxes, stored on the dice report dated 4/19/23, removal of medical equipment to the building to reduce the othering the facility.	F 925			
	should be plugged	in for use. He stated that the the kitchen floor was repaired				

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NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT CONCORD		515 L	EET ADDRESS, CITY, STATE, ZIP CODE LAKE CONCORD ROAD NE LCORD, NC 28025	C 07/28/202 <u>3</u>	
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F 925	tiles still needed re expected the dish the floor dry. He shocken equipment on the ground outsitems should be plumpster. He state undergoing renovasecond commerciathat emptying the on a schedule. He company emptied will, and that the fathe dumpsters to be	age 81 2022 and as a result a few floor spair. He stated that he pit area to be kept clean and tated that he was aware that and other items were stored side the facility and that these aced in the commercial ed that the facility was currently ations and so they secured a all dumpster to store trash, but commercial dumpster was not stated that the waste removal the commercial dumpsters at acility was currently waiting for the emptied so that the broken ced in the dumpster for	F 925		